Chevron High
Deductible Health Plan
Summary Plan Description (SPD)
Effective January 1, 2015
This document describes the Chevron High Deductible Health Plan (also referred to as the HDHP), as of January 1, 2015, that Chevron sponsors for eligible employees. It includes a description of the following components of this plan:

- Medical Coverage – UnitedHealthcare (UHC)
- Prescription Drug Program – Express Scripts

This information constitutes the SPD of the HDHP as required by the Employee Retirement Income Security Act of 1974 (ERISA). These descriptions don't cover every provision of the plans. Many complex concepts have been simplified or omitted in order to present more understandable plan descriptions. If these plan descriptions are incomplete, or if there's any inconsistency between the information provided here and the official plan texts, the provisions of the official plan texts will prevail.

Chevron Corporation reserves the right to change or terminate 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.

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

Key Health Benefit Contacts ................................................................. 3

Overview of the High Deductible Health Plan ........................................ 4
   Eligible Employees ........................................................................... 6
   Participation .................................................................................... 11
   How Much You Pay for Coverage .................................................... 21
   Combined Deductible ..................................................................... 22
   Out-of-Pocket Maximum ................................................................. 24
   Wellness Programs .......................................................................... 26
   Health Support Wellness Programs ................................................ 27

Medical Coverage in the High Deductible Health Plan .............................. 28
   How the Plan Works ........................................................................ 29
   What the Plan Pays ........................................................................ 31
   Expenses That Aren’t Covered Under the Plan ................................. 54
   Health Care Review ........................................................................ 60
   Medical Claims and Appeals ........................................................... 66
   If You're Covered by More Than One Health Plan ......................... 77

Basic Vision Coverage in the High Deductible Health Plan ...................... 80

Prescription Drug Coverage in the High Deductible Health Plan ............. 85
   Overview ....................................................................................... 86
   Prescription Drug Benefit Overview .............................................. 87
   Covered Medication ....................................................................... 88
   Drugs That Aren’t Covered ............................................................ 94
   Networks ....................................................................................... 95
   Home Delivery Pharmacy Program ............................................... 97
   Special Vacation Supply of Prescription Medication ....................... 99
   Prescription Drug Claims and Appeals ......................................... 100
   If You’re Covered by More Than One Health Plan ....................... 111

How to File a Claim For Eligibility ........................................................... 115

Other Plan Information ......................................................................... 118
   Administrative Information ............................................................ 119
   HIPPA .......................................................................................... 123
   Your ERISA Rights ....................................................................... 124
   Other Legislation That Can Affect Your Benefits ........................... 127
   Third Party Responsibility ............................................................. 132

Continuation Coverage and COBRA Coverage ...................................... 135

Glossary .......................................................................................... 150

Company Contributions to Medical Coverage ...................................... SUPPLEMENT
## Key Health Benefit Contacts

### Human Resources (HR) Service Center
If you have questions regarding your plan options, eligibility and enrollment, please call the HR Service Center.

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

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

- hr2.chevron.com

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

- hr.chevron.com/northamerica/us/

### UnitedHealthcare
High Deductible Health Plan – medical coverage

- www.myuhc.com
- Mobile App - UnitedHealthcare Health4Me™
- 1-800-654-0079

### VSP Vision Services
VSP is the insurer for the vision benefits you receive through the Chevron Vision Program.

- www.vsp.com/go/chevron
- 1-800-877-7195 (Inside the U.S.)
- 916-851-5000 (Outside the U.S.)
  Press “0” for operator assistance.

### Express Scripts
High Deductible Health – prescription drug coverage

- www.Express-Scripts.com
- 1-800-987-8368

### ADP Benefit Services
COBRA and Continuation Coverage

- 1-888-825-5247 (Inside the U.S.)
  Select option 2, then " * "
- 610-669-8595 (Outside the U.S.)
  Select option 2, then " * "
Health Savings Account (HSA)
General information about an HSA, BenefitWallet HSA updates and Chevron’s company contribution to the HSA
Effective January 1, 2017
health savings account (HSA)
changes to your benefits that take effect january 1, 2017

A health savings account (HSA) is a personal account separate from your Chevron benefits. It works like a regular bank account, but you don’t currently pay federal income taxes on money you deposit. And when you use the money in your account to pay for qualified medical expenses, under current IRS rules, you won’t pay federal income taxes on the money, either.

Unlike the Health Care Spending Account (See Page 27) — a flexible spending account — your savings grow from year to year. There is no use it or lose it rule. And you can take your money with you if you change plans or when you leave Chevron. You can use an HSA to pay for qualified medical expenses this year or at any point in the future — even in retirement.

Participating in an HSA is a voluntary choice. There are a lot of IRS rules about who can open and contribute to an HSA, how it’s used, and how taxes work. This section provides only basic information to help you understand how HSAs work in general. It’s your responsibility to understand the complete rules and take action if you decide an HSA is right for you. Chevron does not provide an HSA, and Chevron cannot offer counsel about HSAs.

you own it, you take it with you

A big advantage of an HSA is that there is no use it or lose it rule. You have control of your account, and you choose when to spend the funds, if at all. The money in your account belongs to you, even if you change jobs or medical plans. And while the IRS limits how much you can contribute in a year, there is no overall limit to the total balance you can carry in your account.

While you have to participate in a high deductible health plan and meet other specific eligibility requirements to open and contribute to an account, you can still use all the funds in your account regardless of what medical plan you’re participating in, no matter who you work for, and at any age — even in retirement. The only requirement is that you use the funds to pay for qualified medical expenses as defined by the IRS. (See Publication 502 available at www.irs.gov for a list.)

who is eligible to participate in an HSA?

With those federal tax advantages come some pretty strict rules from the IRS about who can open and contribute to an HSA, how it’s used, and how taxes work. We’ve listed some of the most common requirements here, but it’s up to you to understand any additional rules and restrictions that might apply to your situation.

You should consult your tax advisor and read the full eligibility requirements available at www.irs.gov in IRS Publication 969 to ensure you’re eligible to open and contribute to an HSA.

• You must be enrolled in an HSA-compatible plan. Good news, the Chevron High Deductible Health Plan (HDHP) and the Chevron High Deductible Health Plan Basic (HDHP Basic) are both HSA-compatible plans. If you’re eligible for and enroll in the HDHP or HDHP Basic, you may be eligible to open and contribute to an HSA for as long as you remain eligible under the IRS rules.

• You are covered by no other health coverage, unless it’s an allowed plan, such as another high deductible health plan, a dental plan, a vision plan, or additional insurance that provides benefits for a specific disease or illness or a fixed amount per day of hospitalization.

• You are not enrolled in or covered by a health flexible spending account (FSA) or a Health Reimbursement Arrangement (HRA). This means you can’t be enrolled in Chevron’s Health Care Spending Account (HCSA). It also means your spouse, if applicable, cannot be enrolled in a flexible spending account or HRA that could reimburse your expenses. Participation in Chevron’s Dependent Day Care Spending Account (DCSA), another kind of flexible spending account, is still okay. And if you qualify for the $250 Wellness Credit on January 1, 2017, your credit will not be deposited into the HCSA but will instead be added to a Limited Purpose Health Care Spending Account (LHCSA), which is allowed under IRS rules.

• You do not have coverage under your spouse’s employer’s plan or any other coverage that pays first dollar for any benefit covered by the HDHP or HDHP Basic.

• You are not enrolled in Medicare.

• You cannot be claimed as a dependent on someone else’s tax return.

Important: If you are enrolled in the Health Care Spending Account (HCSA), you cannot open or contribute to the BenefitWallet health savings account (HSA) or an HSA with another financial institution. This means that if you change to the Chevron High Deductible Health Plan (HDHP) or Chevron High Deductible Health Plan Basic (HDHP Basic) mid-year due to a qualifying life event, or if you return from an expatriate assignment and want to enroll in the High Deductible Health Plan (HDHP) or HDHP Basic, you cannot open and contribute to the BenefitWallet HSA if you have already elected to enroll in the HCSA for the current year.
how an HSA works

It works like a bank account.
It’s important to remember your HSA works like a bank account — with some extra rules tacked onto it. You can pay for qualified medical expenses only if you have enough money in your HSA to cover the cost. Like a bank account, only the money you’ve actually contributed is available to you. So even if you plan to contribute $1,000 for the year, if you only have $300 in your HSA at the time, that’s all you can spend until the balance grows larger. If you don’t have enough money in your HSA to cover a qualified medical expense, you’ll need to pay the balance from your own pocket. But you can pay yourself back later, when you have more money in your HSA. And there’s no time limit for reimbursement if it’s for a qualified medical expense.

Unlike a flexible spending account, there is no use it or lose it rule, and you don’t have to send in receipts or a claim form that has to be approved before you can be reimbursed. You can reimburse yourself two weeks later or many years later. But don’t forget to hold onto the receipt and other documentation to prove to the IRS the withdrawal was permissible under IRS rules. What matters is that the expense occurred on or after the date the HSA was established and the expense was a qualified medical expense. Read IRS Publication 502 available from www.irs.gov to learn more about what’s considered a qualified medical expense.

Several ways to pay for expenses.
Since your HSA is a bank account, the methods of payment available to you are similar. Keep in mind this list will vary depending on the HSA financial institution you choose, but they generally include the option to use a debit card, write a check, use online bill pay or pay directly from your pocket and pay yourself back later.

Keep all your receipts.
Save all your receipts for a qualified medical expense. If the IRS asks, you must be able to prove you used your HSA money only to pay or reimburse yourself for a qualified medical expense. Read IRS Publication 502 available on www.irs.gov to learn more about what’s considered a qualified medical expense.

choosing an HSA

If you are eligible to open an HSA, then you can choose one from any institution that offers them. Employees enrolled in the Chevron HDHP and HDHP Basic have access to contribute to a BenefitWallet HSA with the convenience of payroll deductions, as long as you meet the eligibility requirements to open an HSA. This HSA is separate from your Chevron benefits. Chevron does not provide an HSA, and Chevron cannot offer counsel about HSAs.

If you open an HSA with another financial institution, you’ll be responsible for making contributions on your own because payroll deduction won’t be available. But eligible employees enrolled in Chevron’s HDHP or HDHP Basic may be able to make contributions to the BenefitWallet Health Savings Account (HSA) with the convenience of payroll deductions. And in 2017, Chevron will also prefund up to a maximum of $500, $750 or $1,000 to the BenefitWallet HSA for eligible employees enrolled in the Chevron HDHP or HDHP Basic in 2017. See Page Page 25-26 for details.

How to open a BenefitWallet HSA
You can open a BenefitWallet HSA from the Benefits Connection website after you’re enrolled in the Chevron HDHP or HDHP Basic. You’re still responsible for making sure you are eligible to open and contribute to an HSA because Chevron does not determine your eligibility for an HSA beyond meeting the requirement to be enrolled in the Chevron HDHP or HDHP Basic.

If eligible, you can open a new BenefitWallet HSA during open enrollment or at any time during the year, as long as you aren’t enrolled in the Health Care Spending Account (HCSA). But note the enrollment deadlines below if you want to take advantage of Chevron contributions to your BenefitWallet HSA in 2017. You can change, stop or start contributions to your existing BenefitWallet account at any time from Benefits Connection or by calling the HR Service Center. (Changes are not retroactive.) And you can take your money with you if you change medical plans or you leave Chevron.

When you first open the BenefitWallet HSA, know that typically the effective date will be pending until you complete the account’s enrollment requirements. This is important to know because you can only use your account to pay for eligible expenses that occur on or after your HSA effective date.

Do you currently have a BenefitWallet HSA?
If you currently have BenefitWallet HSA because you are currently participating in the Chevron HDHP or you participated in the Chevron HDHP in the past, your employee 2017 contribution amount will be automatically reset to $0 for 2017. This is because the Chevron company contribution does apply to the 2017 maximum annual contributions allowed by the IRS, so you’ll need to adjust your 2017 employee contribution accordingly. You can change your employee contribution at open enrollment (October 17 through October 28, 2016) or at any time from the Benefits Connection website or by calling the HR Service Center.
**Important: Complete the required financial information as soon as possible**

If you are opening a BenefitWallet account for the first time, submitting your election to contribute to the BenefitWallet HSA is just the first step. When you submit your election, you’ll receive a link to open your account electronically and receive a Welcome Kit in the mail. BenefitWallet will collect personal information— as required by federal banking regulations under the USA Patriot Act—that is needed to open a bank account. If you don’t provide the requested information by the deadline, your account will not be opened. In addition, the effective date of your HSA is pending until you complete the information requirements. This is important to know because you can only use your account to pay for eligible expenses that occur on or after your HSA effective date. Contact BenefitWallet directly if you have questions or need additional information.

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**wellness credits and the HSA**

If you are enrolled in the HDHP or HDHP Basic on January 1, 2017, and you met the requirements between January 1, 2016 and October 28, 2016 to qualify for health rewards, 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 Health Care Spending Account (HCSA) if you are enrolled in the HDHP or HDHP Basic. 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. You’ll receive a separate special purpose debit card to use to pay for eligible expenses along with more instructions later this year. More information about the 2016 health rewards program is available on hr2.chevron.com/wellness.

Go to hr2.chevron.com and click on 2017 Benefit Changes to learn more about an HSA, watch a video or access other tools and resources provided by BenefitWallet.

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**IRS contribution limits to an HSA**

The IRS limits how much you can contribute to your HSA for each year. Your contribution limits are determined by the level of coverage you’ve selected in a qualifying, high deductible health plan, such as the Chevron HDHP or HDHP Basic. Monitor your contributions carefully. It is your responsibility to track the total contributions during the year—including your contributions, Chevron’s contributions, and contributions from other sources. Chevron cannot track your contributions against the maximum annual limit. If you contribute over the limit, you may be subject to taxes and penalties. While the IRS limits how much you can contribute in a year, there is no limit to the balance you are allowed to carry over into the next year, and there’s no overall limit to the total balance you can carry in your account.

For 2017 the IRS HSA contribution limits are:*  
- You Only: **$3,400**  
- You + One Adult: **$6,750**  
- You + Child(ren): **$6,750**  
- You + Family: **$6,750**

*You are allowed to make an extra $1,000 in catch-up contributions starting in the calendar year in which you turn age 55.

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**Chevron contributions to the BenefitWallet HSA**

Many people like the idea of having more control over health care dollars and saving for the future, but making the switch to the HDHP or HDHP Basic may feel daunting, especially if you don’t already have some savings to help cover that first year at a higher deductible.

To help you build your HSA account more quickly from the start, in 2017, Chevron will prefund up to a maximum of $500, $750 or $1,000 to the BenefitWallet HSA for eligible employees enrolled in the Chevron HDHP or HDHP Basic in 2017, subject to timely enrollment and BenefitWallet HSA account opening.

**2017 Chevron Contribution — BenefitWallet HSA**

Chevron’s contribution amount depends on your coverage tier.

- You Only: **$500**
- You + One Adult: **$750**
- You + Child(ren): **$750**
- You + Family: **$1,000**

*Eligible employees hired or rehired on or after July 1, 2017 will receive half the applicable Chevron HSA contribution for 2017, subject to timely enrollment and BenefitWallet HSA account opening.*
**how the contribution works**

If you meet the requirements and deadlines below, Chevron will automatically deposit the amount that corresponds to your coverage level into your open BenefitWallet HSA.

- If you are an active, eligible employee on January 1, 2017, the deposit to your account will occur by the end of **January 2017**.
- Some states, including California and New Jersey, tax employer contributions to an HSA. Taxes, if any, will be determined and applied based on the state where you live on the date that Chevron funds your account.
- Chevron’s contribution amount applies toward the 2017 maximum annual contributions allowed by the IRS. Be sure to take this into account when you elect your HSA contribution level for 2017.
- Chevron’s contributions to the BenefitWallet HSA are not conditional upon your contributions. When you open your account or make your 2017 contribution election, you can decide to contribute to your account — or not to contribute at all.
- This is a one-time contribution; you will receive the full amount for which you are eligible at the time of the deposit.
- You can begin to use the funds for qualified medical expenses as soon as the funds are in your account.
- The 2017 company contribution to your account is based on the coverage level you choose during open enrollment or when you make your new hire or rehire enrollment elections. If you experience a qualifying life event during the year that changes your HDHP or HDHP Basic coverage level, you will neither receive an additional company contribution, nor will you be required to return a portion of the company contribution.
- If you are eligible and decide to enroll in a BenefitWallet HSA **after** open enrollment or **after** your 31-day new hire or rehire enrollment period, you will not be eligible to receive the 2017 company contribution. You are still able to contribute your own funds to the BenefitWallet HSA.

**requirements and deadlines to receive chevron’s 2017 contribution**

- You must be enrolled in the Chevron High Deductible Health Plan (HDHP) or the Chevron High Deductible Health Plan Basic (HDHP Basic) on January 1, 2017. If you are not already participating in these plans, you can enroll during the upcoming Chevron open enrollment period October 17 through October 28, 2016.
- You must be an active U.S.-payroll employee eligible to participate in the HDHP or HDHP Basic. Retirees are not eligible to receive a company contribution to the BenefitWallet HSA. You’re still responsible for making sure you are eligible to open and contribute to an HSA because Chevron does not determine your eligibility for an HSA beyond meeting the requirement to be enrolled in the Chevron HDHP or HDHP Basic. See IRS **Publication 969** available on [www.irs.gov](http://www.irs.gov) for further details.
- If this is your first time to open a BenefitWallet HSA, you must make an election to participate in the BenefitWallet HSA by **October 28, 2016**, to receive the company contribution. In addition, you must timely complete your responsibilities to actually open the BenefitWallet HSA. Remember, even though you elect to participate, you will not be able to use the funds for qualifying medical expenses until you have completed the requirements necessary to open the account and the account is funded. See the **How to open a BenefitWallet HSA** information on Page 24 for instructions.
- If you currently have BenefitWallet HSA due to current or past HDHP participation, as long as you are enrolled in the HDHP or HDHP Basic on January 1, 2017 and you’re still eligible to participate in an HSA in 2017, you don’t need to do anything further to receive the 2017 company contribution.
### Chevron HR Service Center

<table>
<thead>
<tr>
<th><strong>Phone Numbers</strong></th>
<th>Please note the HR Service Center can answer questions about 2017 benefits starting <strong>October 17, 2016.</strong></th>
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<tr>
<td></td>
<td>• 1-888-825-5247 when calling from inside the U.S.</td>
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<td>• 610-669-8595 when calling from outside the U.S.</td>
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<td></td>
<td>• 6 a.m. to 5 p.m. Pacific time (8 a.m. to 7 p.m. Central time)</td>
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<td>• Monday through Friday (except on holidays).</td>
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### BenefitWallet HSA (HSA)

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<th><strong>Claims Administrator</strong></th>
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<td><strong>Phone Numbers</strong></td>
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<td></td>
<td>• 1-855-234-7722</td>
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<td><strong>HR Service Center</strong></td>
<td>To enroll or change coverage, contact the Chevron HR Service Center:</td>
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<tr>
<td></td>
<td>• 1-888-825-5247 (Inside the U.S.)</td>
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<td>• 610-669-8595 (Outside the U.S.)</td>
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| **Website**                   | **BenefitWallet**                                                                                       |
|                               | • [www.mybenefitwallet.com](http://www.mybenefitwallet.com)                                              |

**Benefits Connection**
To enroll or change coverage:
• [hr2.chevron.com](http://hr2.chevron.com) and click **Benefits Connection**
Update to the Summary Plan Description
Effective January 1, 2017

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

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

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

This SMM applies to the following summary plan description:

- **January 1, 2015 High Deductible Health Plan (HDHP) Summary Plan Description** (both the individual SPD posted online and the Your Chevron Health Benefits Summary Plan Description for U.S.-Payroll Employees compilation available in print.)
meet anthem blue cross

Chevron has selected Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross or Anthem) to be the claims administrator for the Chevron Medical PPO Plan, the High Deductible Health Plan (HDHP), and the High Deductible Health Plan Basic (HDHP Basic) effective January 1, 2017. UnitedHealthcare (UHC) will continue to be the claims administrator for the remainder of 2016. This section will describe what you need to know about your Medical PPO Plan, HDHP or HDHP Basic because of the change to Anthem, including what you’ll need to know during the transition to Anthem and how to access your benefits starting in January.

what’s staying the same

Plan coverage
The move to Anthem is an administrative change and does not alter the benefits provided by your medical, prescription drug or basic vision coverage. The types of services the medical plans cover remain the same. The plans will continue to offer comprehensive coverage for the types of medical services you’d expect, including office visits, emergency services, hospital care, lab services, outpatient care, pregnancy and newborn care and rehabilitative services. Please note that changes are typically made to your medical plans each year, irrespective of a change in claims administrators. As announced in August, there are some plan design changes coming in 2017, as described later in this section.

Prescription drug, basic vision, mental health and substance abuse coverage
The move to Anthem only affects your medical coverage.

• Express Scripts will continue to be the claims administrator for your prescription drug plan.
• If you are enrolled in the Medical PPO Plan, the HDHP or the HDHP Basic, you’re automatically enrolled in the Vision Program for basic vision coverage. VSP Vision Care (VSP) will continue to be the claims administrator for this coverage.
• If you are enrolled in the Medical PPO Plan, the HDHP or the HDHP Basic, you’re automatically enrolled in the Mental Health and Substance Abuse (MHSA) Plan. Beacon Health Options (Beacon) will continue to be the claims administrator for this coverage.

Eligibility rules
Who is covered, and who you can cover — the eligibility rules for eligible employees and their eligible dependents — are the same. We recently announced new eligibility rules and plan options for eligible retirees and their eligible dependents. However, the eligibility rules while you’re an active employee — regardless of your age — have not changed. Eligible employees can continue to add and drop eligible dependents during open enrollment or within 31-days of a qualifying life event while you’re an active employee.

Preventive care
All plans will continue to include 100 percent coverage with no deductible for certain preventive care services, as specified by the Affordable Care Act, when you see a network provider. Additional preventive screenings and services may also be covered, depending on factors like your age and gender. If you see an out-of-network provider, your visit is subject to the deductible and copayments or coinsurance will apply. Go to hr2.chevron.com and click on 2017 Benefit Changes to see a list of covered preventive services.

Out-of-pocket maximum protection
All plans will continue to include out-of-pocket maximum protection, which means there’s a defined limit on how much you need to pay for covered services during a plan year. This is an important feature because it protects you in the event of major medical expenses during the year.

Access to tax-advantaged health accounts
All of the plans will continue to offer access to one of two tax-advantaged health accounts — either the Health Care Spending Account (HCSA) or a health savings account (HSA). Health accounts can help you pay for your out-of-pocket health care costs. Enrolling in a health account is a voluntary choice, and the account you can use varies based on the medical plan you choose. See Page 22 to learn more.
what’s changing

Who to contact
There are new phone numbers and website addresses for the claims administrator of your medical services. See Page 73.

Provider network for medical services
A network is a group of independent health care providers — doctors, hospitals and other facilities — that have agreed with your health plan to charge contracted rates for services provided to plan members. Network providers save you money directly by reducing your out-of-pocket costs. They also help to lower overall claim costs for all of us. With a new claims administrator comes a new provider network. Go to hr2.chevron.com and click on 2017 Benefit Changes to access special links that make it easier to research your provider options.

New member number and medical ID card
You will receive a new medical ID card with your new member number in December. Continue to use your current UnitedHealthcare member ID card until December 31, 2016, and begin using your new Anthem card on January 1, 2017 for all medical services.

• You will not receive a new ID card from Express Scripts for prescription drugs.
• You will not receive a new ID card from VSP for basic vision coverage as a result of this change to Anthem.
• You will not receive new ID cards from Beacon for mental health and substance coverage.

Claim form for medical services
There will be a new claim form to be reimbursed for medical services received from an out-of-network provider. Go to hr2.chevron.com and click on 2017 Benefit Changes for the new form, go to the Anthem website in January, or call Anthem to request a form.

continuation of care
Remember, the Medical PPO, HDHP and HDHP Basic are preferred provider organization plans, so you can continue to use any provider you choose, network or out-of-network. However, the deductible and out-of-pocket amounts are lower when you see a network provider.

Continuation of care allows you to continue to receive care for certain conditions from providers who do not participate in the Anthem network. You might need continuation of care if you are already in active treatment for certain ongoing conditions on January 1, 2017. Examples of conditions eligible for continuation of care might include:

• Be in an active course of treatment for an acute medical condition.
• Be pregnant, regardless of trimester.
• Have a terminal illness.
• Have a surgery or other procedure that has been authorized by the previous plan scheduled to occur within 180 days of January 1, 2017.

To qualify for this continuation of care benefit, you must apply for it by March 1, 2017. The application form is available on hr2.chevron.com (click on 2017 Benefit Changes) and is also available by calling Anthem (see Page 73). A letter will be sent to you outlining the decision or requesting additional information, if needed. You can contact Anthem to confirm if your request has been received.

If approved, you’ll have a set amount of time — typically a minimum of 180 days — to continue to see your provider and continue to receive the network level of coverage for that condition. After that, you will need to choose a doctor from within the Anthem network to receive the network level of coverage. Keep in mind that continuation of care approval does not guarantee a treatment is medically necessary, and it also doesn’t mean you are pre-approved for any medical services. All medical services must be medically necessary. Pre-approval by Anthem may still be required.

Do I need to find a new doctor?
You can continue to use any provider you choose, network or out-of-network, under the Medical PPO Plan, HDHP or HDHP Basic. This means you aren’t required to find a new provider. If your current doctor or hospital is not on the Anthem network, it’s still your choice to continue to use that provider or locate a new network provider. Just be sure you understand how that choice affects your out-of-pocket costs.

Do I need to get a new prescription?
Maybe. If you intend to continue to see the prescribing physician, then you will not need to get a new prescription as a result of the change to Anthem, and you can continue to use mail-order for your current prescriptions, if applicable. However, if you intend to change prescribing physicians and need to refill a prescription on or around January 1, 2017, you may need to plan ahead and get that refill prior to January 1, 2017. You may also need to schedule an appointment with your new physician as soon as possible in 2017 to have your prescription transferred, and if you use mail-order for this prescription, be sure to contact Express Scripts Member Services at 1-800-987-8368 for any steps you need to take to ensure your delivery continues as expected.
claims for medical services

If you use an out-of-network provider, typically you’ll need to submit a claim to be reimbursed for covered medical services. The medical plans generally do not allow benefits to be assigned to an out-of-network provider.

Submit 2016 claims to UnitedHealthcare by June 30, 2017

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

How to submit 2017 claims to Anthem Blue Cross

Use the Anthem claim form for covered medical services on or after January 1, 2017. You can submit claim forms and bills by mail or fax. Keep a copy of your completed claim form and receipts for your records. You can track the status of your claim by contacting Anthem. Go to hr2.chevron.com and click on 2017 Benefit Changes for the new form, go to the Anthem website in January, or call Anthem to request a form.

anthem website

You’ll have access to the full Anthem site starting on January 1, 2017. Note that you’ll need some of the information printed on your ID card to register for access to the site. If you’re searching for a provider prior to January 1, 2017, you don’t need to register; go to hr2.chevron.com and click on 2017 Benefit Changes to access a provider search tool.

• Go to anthem.com/ca starting January 1, 2017.
• Click Register Now and follow the instructions on the screen.

Find a provider

Go to hr2.chevron.com and click on 2017 Benefit Changes to access special links that make it easier to research your provider options.

anthem anywhere mobile app

With the Anthem Anywhere app, you can manage your benefits anytime and anywhere you go. Just search for Anthem Anywhere in iTunes, the Apple Store or Google Play and download the app starting January 1, 2017. With the app you can:

• Find a doctor. Search for a doctor, specialist, urgent care or hospital close by.
• Get your ID card. Share, fax, or email your ID card right from your smartphone.
• Check your claims. Find out what your doctor billed, how much was paid and if you owe anything.
• Estimate your costs. See what nearby doctors and facilities charge for a procedure. You can compare providers on cost and quality.
• View your medical benefits. See your copayments, deductibles, your percentage of the costs and other important plan benefit information.
prescription drug program

If you are enrolled in the Medical PPO Plan, the High Deductible Health Plan (HDHP) or the new High Deductible Health Plan Basic (HDHP Basic), you automatically have prescription drug coverage through the Prescription Drug Program with Express Scripts. The Prescription Drug Program currently has prior authorization, Preferred Step Therapy and Drug Quantity Management programs in place. There are administrative changes to these programs, only. You don’t need to do anything.

You’ll be notified by Express Scripts if your medication is subject to any of these programs during 2017, including what you need to do, if anything. Starting October 17, 2016, to find out if your prescription drug is subject to prior authorization, Preferred Step Therapy and Drug Quantity Management programs, contact Express Scripts Member Services at 1-800-987-8368, or review the documents and links available from hr2.chevron.com. Click the 2017 Benefit Changes link to get started.

See the information below for a quick review about what prior authorization, Preferred Step Therapy, and Drug Quantity Management means.

• The Prescription Drug Program covers some drugs only if they’re prescribed for certain uses (or only up to certain quantity levels). For this reason, some medications will require your prescribing doctor to provide additional clinical information so that use of the medication can be approved in advance before you can receive Prescription Drug Program benefits. This is called prior authorization.

• Certain drugs are covered by the Prescription Drug Program only if preferred drugs — which include generics — are tried first. This is called Preferred Step Therapy. If your medication is subject to Preferred Step Therapy, this means that you will be required, when clinically appropriate, to try a preferred drug before Express Scripts will authorize coverage for the use of non-preferred drugs.

• Drug Quantity Management is a program included in the Prescription Drug Program that’s designed to make the use of prescription drugs safer and more affordable. It provides you with medicines you need for your good health and the health of your covered dependents, while making sure you receive them in the amount — or quantity — considered safe and most cost effective.
Aside from the switch to a new claims administrator (see Page 5) — Anthem Blue Cross — this section provides more detail about other changes to the Chevron High Deductible Health Plan (HDHP) that will be offered to eligible employees effective January 1, 2017.

new monthly premium cost
Chevron will currently continue to share the monthly cost of coverage — the premium — with you.

<table>
<thead>
<tr>
<th>High Deductible Health Plan (HDHP)</th>
<th>2017 Employee Monthly Premium*</th>
</tr>
</thead>
<tbody>
<tr>
<td>$28</td>
<td>You only</td>
</tr>
<tr>
<td>$56</td>
<td>You + One adult</td>
</tr>
<tr>
<td>$46</td>
<td>You + Child(ren)</td>
</tr>
<tr>
<td>$74</td>
<td>You + Family</td>
</tr>
</tbody>
</table>

*These rates do not include the 2017 tobacco surcharge, if applicable.

do I need to enroll during open enrollment, October 17 through October 28, 2017?

- If you are currently enrolled in the High Deductible Health Plan (HDHP), your enrollment will automatically continue effective January 1, 2017. You do not have to make an enrollment election during open enrollment, unless you want to make a change to your coverage.
- If you want to enroll in the new High Deductible Health Plan Basic (HDHP Basic), you need to make an enrollment election during the upcoming open enrollment period. The HDHP Basic generally covers the same services as the HDHP. The primary difference between the two plan options are your out-of-pocket costs: the premiums, deductibles, copayments and coinsurance. See Page 16 to learn more about the HDHP Basic.

prescription drug program
If you are enrolled in the HDHP, you automatically have prescription drug coverage through the Prescription Drug Program with Express Scripts. See Page 8 for information about the 2017 Prescription Drug Program.

tobacco surcharge
Chevron has established a tobacco surcharge for medical and supplemental life insurance coverage. This means there are different monthly premium rates for HDHP coverage for tobacco and non-tobacco users. See Page 47 for tobacco surcharge information.

second opinion for certain surgeries
Starting in 2017, Chevron requests that you seek a second opinion through the Health Decision Support Program prior to receiving knee, hip, back or spine surgery (on a non-emergency basis). It’s your choice to use the second opinion service or decline to use the second opinion service for these four procedures. However, if you do not seek a second opinion for these procedures you will be responsible for an additional $400 of out-of-pocket costs for the procedure, whether or not you’ve met your annual deductible. See Page 30 for more information.

health savings account compatible (HSA)
If you enroll in the HDHP, you may also be eligible to open and contribute to a health savings account (HSA). Enrollment in the HDHP gives you the keys to open an HSA, but it’s your responsibility to determine if you’re eligible, choose an HSA provider and then open and contribute to an account. Consult your tax advisor and read about the requirements in IRS Publication 969, available at www.irs.gov to determine if you meet the requirements to open and contribute to an HSA.

Access to the BenefitWallet HSA
If you are eligible to open an HSA, then you can choose one from any institution that offers them. Employees enrolled in the Chevron HDHP have access to contribute to the BenefitWallet HSA with the convenience of payroll deductions, as long as you meet the eligibility requirements to open an HSA.

Chevron contributions to the BenefitWallet HSA in 2017
In 2017, Chevron will prefund up to a maximum of $500, $750 or $1,000 to the BenefitWallet HSA for eligible employees who are enrolled in the Chevron HDHP in 2017. Please see Page 25-26 to learn more about this opportunity.
new annual combined deductibles

The Chevron HDHP has one combined deductible for medical, prescription drugs (both retail and mail-order), mental health and substance abuse services. This means you’ll have to pay the full cost for covered services and supplies until you reach the deductible for the year. Effective January 1, 2017, the following changes to the HDHP deductibles will take effect.

Medical, prescription drug, mental health and substance abuse services, combined

There are now different deductible amounts for covered services depending on if you see a network or an out-of-network provider. The network deductible for You + Family will decrease in 2017 for this plan. Amounts paid for covered services provided by a network provider also count toward the out-of-network annual deductible. Amounts paid for covered services provided by an out-of-network provider also count toward the network annual deductible.

<table>
<thead>
<tr>
<th>Coverage Category</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>You only</td>
<td>$2,650</td>
<td>$5,300</td>
</tr>
<tr>
<td>You + One adult</td>
<td>$5,300</td>
<td>$10,600</td>
</tr>
<tr>
<td>You + Child(ren)</td>
<td>$5,300</td>
<td>$10,600</td>
</tr>
<tr>
<td>You + Family</td>
<td>$5,300</td>
<td>$10,600</td>
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</tbody>
</table>

Each covered individual has a maximum deductible equal to the You only amount.

new out-of-pocket maximums

The Chevron HDHP has one combined out-of-pocket maximum for medical, prescription drugs, mental health and substance abuse services. Effective January 1, 2017, the following changes to the HDHP out-of-pocket maximum will take effect.

Medical, prescription drug, mental health and substance abuse services, combined

There are different out-of-pocket maximums for medical, prescription drug, mental health and substance abuse services combined, depending on if you see a network provider or an out-of-network provider. These out-of-pocket amounts will change in 2017 for this plan. Note: While covered mental health and substance abuse services will apply to the combined out-of-pocket maximum, know that, depending on your usage, you may actually reach the MHSA Plan’s out-of-pocket maximum for covered mental health and substance abuse services before you reach the HDHP’s combined annual out-of-pocket maximum amount. See Page 34 for more information about the MHSA out-of-pocket maximum amount. Amounts paid for covered services provided by a network provider also count toward the out-of-network maximum. Amounts paid for covered services provided by an out-of-network provider also count toward the network maximum.

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<td>You + Family</td>
<td>$10,000</td>
<td>$20,000</td>
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</tbody>
</table>

Each covered individual has an out-of-pocket maximum equal to the You only amount.

Learn more

Go to hr2.chevron.com and click on 2017 Benefit Changes to access additional resources that make it easier to understand health plan features.
lifetime maximum

This plan has a lifetime maximum for the following four services: family planning services, transportation and lodging incurred by a transplant recipient and companion(s), nutritional counseling covered by the plan, and temporomandibular joint (TMJ) disorder. Any amounts incurred by the plan participant that count toward the lifetime maximum while UnitedHealthcare was the claims administrator will carry over and also apply toward the lifetime maximum while Anthem Blue Cross is the claims administrator.

new coinsurance amounts for covered medical services

The HDHP currently has different coinsurance amounts for covered medical services depending on if you see a network or an out-of-network provider. That structure won’t change in 2017. It’s still your choice to use any provider you want, but starting in 2017, it’s important to know that using a network provider will save you money. That’s because your share of coinsurance amounts for most covered medical services will increase in 2017.

• The HDHP will continue to include 100 percent coverage with no copayment, coinsurance or deductible for certain preventive care services, as specified by the Affordable Care Act, when you see a network provider. If you see an out-of-network provider you’ll pay 40 percent of maximum allowable amounts and the annual combined deductible will apply.

• If you visit a network provider, you’ll pay 20 percent of maximum allowable amounts, and the plan will pay 80 percent, after you’ve met your annual combined deductible, unless otherwise stated.

• If you visit an out-of-network provider, you’ll pay 40 percent of maximum allowable amounts, and the plan will pay 60 percent, after you’ve met your annual combined deductible, unless otherwise stated.

• There are specific procedures and services for which you’re required to notify the claims administrator in accordance with timelines identified in plan rules. Starting in 2017, if you fail to meet Anthem’s notification requirements for these procedures and services, then you will pay 40 percent of maximum allowable amounts, network or out-of-network, subject to the deductible, unless otherwise stated.

• For emergency room visits, you’ll pay 20 percent of maximum allowable amounts, network or out-of-network, and the plan will pay 80 percent, after you’ve met your annual combined deductible.

• Anthem defines a primary care provider as any of the following: Family Practice, General Practitioner, Pediatrician, Internal Medicine, OB/GYNs, GYNs, Certified Nurse Midwife, Nurse Practitioner, Physician Assistant, and Clinical/Multi Specialty Group. All other professional providers are considered specialists.

  – If you see a network primary care provider, you’ll pay 20 percent of maximum allowable amounts for the office visit, after you’ve met your annual combined deductible, unless otherwise stated.

  – If you see a network specialist, you’ll pay 20 percent of maximum allowable amounts for the office visit, after you’ve met your annual combined deductible, unless otherwise stated.

change to bereavement counseling benefit

Currently, for hospice patients, bereavement counseling is available under the HDHP for the patient’s immediate family members (who are covered by the HDHP) from a licensed social worker or a licensed pastoral counselor within six months after the patient’s death.

Effective January 1, 2017, this bereavement counseling benefit will no longer be available under the HDHP; however, it will remain available through the Mental Health and Substance Abuse Plan. That’s because the benefit under the MHSA Plan has always been and continues to be better than the same benefit in the HDHP. Note that counseling services related to hospice care are not intended to address mental or nervous disorders.

Participate in healthy habits in 2017 and save up to $750 annually on your HDHP premium in 2018

In 2017, when you participate in qualifying healthy activities, you’ll earn points. Earn enough points by the 2017 deadline and you can qualify to save up to $750 annually on your Chevron medical coverage premium in 2018, including the HDHP. More details about the new health rewards opportunity will be released later this year and in early January 2017, when the new program starts.
## High Deductible Health Plan (HDHP)

<table>
<thead>
<tr>
<th>Section</th>
<th>Medical Coverage</th>
<th>Prescription Drug Coverage</th>
<th>Basic Vision Coverage</th>
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<tr>
<td><strong>Claims Administrator</strong></td>
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<td>Express Scripts</td>
<td>VSP</td>
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<td>National Plus Network</td>
<td>VSP Choice</td>
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<td>1-800-987-8368</td>
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<td>Basic vision coverage</td>
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<td>1-800-877-7195 (Inside the U.S.)</td>
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<td>1-916-851-5000 (Outside the U.S.) - press ‘0’ for operator assistance</td>
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<td><strong>Website</strong></td>
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<td><a href="http://www.anthem.com/ca">www.anthem.com/ca</a></td>
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<td>Prescription drug coverage</td>
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<td>Express Scripts app</td>
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tobacco surcharge

effective january 1, 2017

Chevron has established a tobacco surcharge for Chevron medical and supplemental life insurance coverage. This means there are different monthly rates for this coverage for tobacco and non-tobacco users. The tobacco surcharge information here applies to all active U.S.-payroll employees (and those on a leave of absence). There are no changes to the tobacco surcharge for 2017. However, important reminders about the tobacco surcharge are included here for your reference. Go to hr2.chevron.com for additional details about the tobacco surcharge.
**update your tobacco use status for 2017**

Open enrollment is your only opportunity to update your tobacco use status for 2017. Open enrollment — October 17 through October 28, 2016 — is your only opportunity to change your tobacco use status for 2017. If you miss this deadline, you cannot change your 2017 tobacco use status until the next open enrollment period. And you cannot change your 2017 tobacco use status during the year, even if you experience a qualifying life event — like getting married or having a baby.

**do I need to do anything during open enrollment?**

If your 2016 certification status is **Tobacco User, But Commit to Coaching**, you may need to take action during open enrollment to update your 2017 tobacco use status.

- If you do not make a new tobacco use certification during open enrollment, your 2017 tobacco use status will be automatically assigned as **Tobacco User** and the tobacco surcharge will apply to you for all of 2017.
- If you make a new 2017 tobacco use certification during open enrollment, your certification choice will determine whether or not the tobacco surcharge applies to you for all of 2017.

If your 2016 certification status is either **Not a Tobacco User**, **Tobacco User** or **Decline to Disclose**, your 2016 status will continue automatically in 2017 unless you make a change to your status during open enrollment. You do not need to do anything if this designation still accurately describes your tobacco use status.

**2017 surcharge amounts**

There is no change to the tobacco surcharge amounts effective January 1, 2017 so they continue to be as follows:

- **$25** more each month for medical coverage, if enrolled.
- **20 percent** more each month for Chevron Supplemental Life Insurance Plan coverage, if enrolled.

**how to update your tobacco use status**

You can update your tobacco use status October 17 through October 28, 2016, by calling the HR Service Center or by going online to Benefits Connection, the same website you use to make open enrollment elections. Open enrollment instructions will be sent to you in October or you can go to [hr2.chevron.com](http://hr2.chevron.com) to learn more.

**certification choices**

Your 2017 tobacco certification choices and requirements are as follows:

- **Not a Tobacco User.** You will not be subject to the surcharge in 2017.
- **Tobacco User.** If you’re a tobacco user and don’t intend to stop using tobacco, the surcharge will apply to you in 2017.
- **Tobacco User, But Commit to Coaching.** If you commit to complete at least three Tobacco Cessation Specialty Coaching sessions through WebMD between July 1, 2016 and December 31, 2017, the surcharge will not apply to you in 2017. Tobacco Cessation Specialty Coaching combines one-on-one telephone coaching, nicotine replacement therapy and integrated online resources to help participants try to stop using tobacco products. Contact WebMD at **1-888-321-1544** (or **925-842-8346** from outside the U.S.) to enroll. You can use this service again, even if your past attempts to quit have been unsuccessful. Go to [hr2.chevron.com/wellness](http://hr2.chevron.com/wellness) to learn more about this and other Tobacco Free Program resources.
- **Decline to Disclose.** If you decline to disclose your tobacco use, you will be defaulted to Tobacco User and the surcharge will apply to you in 2017.

**What’s considered tobacco use?**

Indicate your tobacco use status only; you don’t have to certify the tobacco use status of your spouse or domestic partner and other dependents for 2017. The definition of tobacco use has not changed for 2017. Any use, regardless of frequency or location, is considered use. This includes daily, occasional or social use. It also includes if it’s used only at your home. Tobacco use means you’ve used any of the following at any point since July 1, 2016:

- **Tobacco** (cigarette, pipe, cigar).
- **Smokeless tobacco** (such as snuff or chewing tobacco).

The Federal Drug Administration now regulates e-cigarettes as tobacco, but they will not be included in the definition of tobacco use for purposes of the 2017 tobacco surcharge. Chevron does, however, intend to change the definition in 2018 to include e-cigarette use as tobacco use.
Update to the Summary Plan Description
Effective January 1, 2016

All changes described in this SMM are effective January 1, 2016 unless otherwise indicated.

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

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

This SMM applies to the following summary plan description:

- **January 1, 2015 High Deductible Health Plan (HDHP) Summary Plan Description** (both the individual SPD posted online and the Your Chevron Health Benefits Summary Plan Description for U.S.-Payroll Employees compilation available in print.)
Tobacco Surcharge Changes

New Tobacco User Trying to Quit requirements for 2016.

Open enrollment – October 19 through October 30, 2015 – is your only opportunity to update your tobacco use status for 2016.

Chevron has established a tobacco surcharge for medical and supplemental life insurance coverage. All active U.S.-payroll employees (and those on a leave of absence) were previously required to certify their tobacco use status. Open enrollment – October 19 through October 30, 2015 – is your only opportunity to change your tobacco use status for 2016. If you miss this deadline, you cannot change your 2016 tobacco use status until the next open enrollment period. And you cannot change your 2016 tobacco use status during the year, even if you experience a qualifying life event – like getting married or having a baby.

If your 2015 certification status is Tobacco User, But Will Try to Quit, you may need to take action during open enrollment to update your 2016 tobacco use status. If you do not make a new tobacco use certification during open enrollment, your 2016 tobacco use status will be automatically assigned as Tobacco User and the tobacco surcharge will apply to you for all of 2016. If you make a new 2016 tobacco use certification during open enrollment, your certification choice will determine whether or not the tobacco surcharge applies to you for all of 2016.

If your 2015 certification status is either Not a Tobacco User, Tobacco User or Decline to Disclose, your 2015 status will continue automatically in 2016 unless you make a change to your status during open enrollment. You do not need to do anything if this designation still accurately describes your tobacco use status.

There is no change to the tobacco surcharge amounts. The tobacco surcharge effective January 1, 2016 is as follows:

- $25 more each month in 2016 for medical coverage.
- 20 percent more each month in 2016 for Chevron Supplemental Life Insurance Plan coverage, if enrolled.

How to Update Your Tobacco Use Status

You can update your tobacco use status by calling the HR Service Center (see Page 8) or by going online to Benefits Connection, the same website you use to make open enrollment elections. Follow the instructions on Page 8 to make open enrollment elections and update your tobacco use status for 2016.
Certification Choices for 2016

Your 2016 tobacco certification choices and requirements are as follows:

- **Not a Tobacco User.** You will not be subject to the surcharge during 2016.
- **Tobacco User.** If you're a tobacco user and don’t intend to stop using tobacco, the surcharge will apply to you in 2016.
- **Tobacco User, But Commit to Coaching.** This is a new certification choice for 2016. See below for details.
- **Decline to Disclose.** If you decline to disclose your tobacco use, you will be defaulted to Tobacco User and the surcharge will apply to you in 2016.

New for Choice for 2016: Tobacco User, But Commit to Coaching

If you commit to complete at least three Tobacco Cessation Specialty Coaching sessions through WebMD between July 1, 2015 and December 31, 2016, the surcharge will not apply to you during 2016. Tobacco Cessation Specialty Coaching combines one-on-one telephone coaching, nicotine replacement therapy and integrated online resources to help participants try to stop using tobacco products. Contact WebMD at 1-888-321-1544 (or 925-842-8346 from outside the U.S.) to enroll. You can also go to hr2.chevron.com/wellness to learn more about this and other Tobacco Free Program resources.

What’s Considered Tobacco Use

Indicate your tobacco use status only; you don’t have to certify the tobacco use status of your spouse or domestic partner and other dependents for 2016. The definition of tobacco use has not changed for 2016. Any use, regardless of frequency or location, is considered use. This includes daily, occasional or social use. It also includes if it's used only at your home. Tobacco use means you’ve used any of the following at any point since July 1, 2015:

- Tobacco (cigarette, pipe, cigar).
- Smokeless tobacco (such as snuff or chewing tobacco).

E-cigarettes do not contain tobacco, so at this time e-cigarettes are not included in the tobacco use definition. However, the Federal Drug Administration is currently reviewing e-cigarettes. We continue to monitor this review and may choose to include e-cigarettes in the tobacco use definition in the future.
High Deductible Health Plan (HDHP)

With the HDHP you pay a low monthly premium in exchange for a high deductible. The HDHP is a preferred provider organization (PPO) health plan. This means you can choose to see any doctor, hospital, pharmacy you want. If you choose a provider outside of the network, you will have a lower level of coverage, which means you might have to pay more for the service. You don’t need a referral to a specialist under this plan. The Chevron HDHP is the only Chevron medical plan that is compatible with a health savings account (HSA). The HDHP offers comprehensive coverage for the major medical services you’d expect, including office visits, emergency services, hospital care, lab services, outpatient care, pregnancy and newborn care and rehabilitative services.

- **Medical Services**: UnitedHealthcare
- **Prescription Drugs**: Prescription Drug Program with Express Scripts
- **Basic Vision**: Automatically covered by the Vision Program for basic vision coverage with VSP.

**Preventive Care**
The HDHP includes 100 percent coverage with no deductible for certain preventive care services as specified by the Affordable Care Act when you see a network provider (100 percent of allowable charges for an out-of-network provider). Additional preventive screenings and services may also be covered, depending on factors like your age and gender.

**Deductibles**
There is one combined deductible in the HDHP for medical, prescription drugs (retail and mail-order), mental health and substance abuse services. This means you’ll have to pay the full cost for covered services and supplies until you reach the deductible for the year. After you meet the deductible, coinsurance or copayments will apply.

**Health Savings Account (HSA)**
If you enroll in the HDHP, you may also be eligible to open and contribute to a health savings account (HSA). An HSA is like a savings plan for health care. Your savings grow from year to year. There is no use it or lose it rule. And you can take your money with you if you change medical plans or you leave Chevron. You can use an HSA to pay for qualified medical expenses this year, three years from now or at any point in the future – even in retirement. It’s your responsibility to learn about the strict eligibility rules and restrictions imposed by the IRS and determine if you meet the requirements to open and contribute to an HSA. Eligible employees enrolled in Chevron's HDHP may be able to make contributions to the BenefitWallet Health Savings Account (HSA) though payroll deductions. You can also choose from HSAs offered by any financial institution that offers them. In addition, you’ll be responsible for understanding how an HSA works and making contributions. Participating in an HSA is a voluntary choice. Chevron does not provide an HSA, and Chevron cannot offer counsel about HSAs. You should consult your tax advisor and read about the requirements in IRS Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans available at [www.irs.gov](http://www.irs.gov). Learn more about an HSA and the BenefitWallet HSA on [hr2.chevron.com](http://hr2.chevron.com). Choose Open Enrollment.

**Mental Health and Substance Abuse (MHSA) Plan**
You’re automatically covered by the MHSA Plan. You can choose to use any provider, network or out-of-network. **Mental health and substance abuse services are subject to the combined deductible.** This means you’ll have to pay the full cost for covered services and supplies until you reach the deductible for the year. See Page 33 for more information about the MHSA Plan.
**Monthly Premium**
This is the fixed amount of money you pay each month to be covered by your health plan. Chevron also currently contributes money each month to help pay for your premium.

<table>
<thead>
<tr>
<th>Monthly Premium Level</th>
<th>For</th>
<th>You Only</th>
<th>You + One Adult</th>
<th>You + Child(ren)</th>
<th>You + Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>$13</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>$28</td>
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<td>$36</td>
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</tbody>
</table>

**Annual Deductible**
This is the amount you pay out of pocket before your health plan begins to help pay for covered health care services.

<table>
<thead>
<tr>
<th>Deductible Level</th>
<th>For</th>
<th>You Only</th>
<th>You + One Adult</th>
<th>You + Child(ren)</th>
<th>You + Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,650</td>
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<tr>
<td>$5,300</td>
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<td>$7,950</td>
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</table>

One combined deductible for medical, prescription drugs, mental health and substance abuse services. Deductible applies to prescription mail-order and mental health and substance abuse services. Doesn’t count toward the deductible: vision and health care this plan doesn’t cover, difference between cost of generic and brand-name drug, or between network and out-of-network pharmacy price, drugs this plan doesn’t cover.

**Out-of-Pocket Maximum**
This amount is the most you will have to pay out of pocket for covered health care services for the year. When you reach this amount, your health plan begins to pay 100 percent of the allowed amount for covered health care services. This amount is important because it protects you in the event you have a year with major health expenses. Your deductible is included in your out-of-pocket maximum. Your monthly premium, charges in excess of the allowable charges, and services your plan doesn’t cover are examples of things not included in the out-of-pocket maximum.

<table>
<thead>
<tr>
<th>Maximum Level</th>
<th>For</th>
<th>You Only</th>
<th>You + One Adult</th>
<th>You + Child(ren)</th>
<th>You + Family</th>
</tr>
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<tr>
<td>$5,000</td>
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<td>$9,000</td>
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<td>$9,000</td>
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<tr>
<td>$12,900</td>
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</table>

Deductible, coinsurance, mental health and substance apply toward the out-of-pocket maximum.

**Tobacco Surcharge**
Chevron has established a tobacco surcharge for medical and supplemental life insurance coverage. This means there are different monthly rates for this coverage for tobacco and non-tobacco users. The rates above do not include a tobacco surcharge. See Page 16 for tobacco surcharge information.

**For More Information**
Be sure to go to hr2.chevron.com for access to a variety of other resources.
Health Care Spending Account (HCSA)
If you enroll in the HDHP, you cannot participate in the HCSA. If you enroll in the HDHP, and you meet the requirements to qualify for health rewards, a Limited Purpose Health Care Spending Account (LHCSA) will automatically be established for you. See Page 14 for more information.

Health Savings Account (HSA) Updates
The IRS limits how much you can contribute to your HSA for each year. Your contribution limits are determined by the level of coverage (such as You Only or You + One Adult) you’ve selected in a qualifying, high deductible health plan, such as the Chevron HDHP. Monitor your contributions carefully. It is your responsibility to track the total contributions you make during the year; Chevron cannot track your contributions against the annual limit. If you contribute over the limit, you may be subject to taxes and penalties. For 2016 the limits are:*  

- **You Only**: $3,350  
- **You + One Adult**: $6,750  
- **You + Child(ren)**: $6,750  
- **You + Family**: $6,750

* You are allowed to make an extra $1,000 in catch-up contributions starting in the calendar year in which you turn age 55.

Changes to Medical Coverage
- Currently, the HDHP requires that another method of pain management has been tried and failed before acupuncture coverage begins. This requirement will be removed effective January 1, 2016.
- Effective January 1, 2016, virtual visits are available for covered health services that include the diagnosis and treatment of low acuity medical conditions for covered persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to [www.myuhc.com](http://www.myuhc.com) or by calling 1-800-654-0079. Note that not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person physician contact is necessary. In addition, benefits under this provision do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities. UnitedHealthcare will provide more information to plan participants when virtual visits become available next year.
Changes to Prescription Drug Coverage
If you are enrolled in the High Deductible Health Plan, you automatically have prescription drug coverage through the Prescription Drug Program with Express Scripts. The prescription drug changes described in this section take effect on January 1, 2016. For additional details, contact Express Scripts Member Services at 1-800-987-8368, or review the documents and links available from hr2.chevron.com. Choose the Open Enrollment link to get started.

New Prior Authorizations
The Prescription Drug Program covers some drugs only if they're prescribed for certain uses or only up to certain quantity levels. For this reason, some medications will require your doctor to provide additional clinical information so that use of the medication can be approved in advance before you can receive plan benefits. This is called prior authorization. The following drugs will require prior authorization effective January 1, 2016:

- Anticoagulants (Pradaxa, Xarelto, Eliquis)
- Suboxone

New Medications Subject to Preferred Step Therapy
Certain drugs are covered by the Prescription Drug Program only if preferred drugs – which include generics – are tried first. This is called Preferred Step Therapy (PST). The following are new classes of medications that will be subject to PST effective January 1, 2016. This means that you will be required, when clinically appropriate, to try a preferred drug before Express Scripts will authorize coverage for the use of non-preferred drugs:

- Topical Acne
  (For example: Cleocin T, Ancanya, Ziana, Veltin, Benzac AC, Azelex)

- Topical Corticosteroids
  (For example: Synalar, Cordran, Halog, Topicort, Diprolene)
Some Compound Medications Not Covered

According to the FDA, compounding is the practice in which a licensed pharmacist combines, mixes or alters ingredients in response to a prescription to create a medication tailored to the medical needs of an individual patient. Individual active ingredients within the compound might be FDA approved, but the FDA does not approve the quality, safety and efficacy of the actual compound with multiple active ingredients.

A number of commonly used primary ingredients for compounds have been identified and will no longer be covered by the Chevron Prescription Drug Program. Beginning January 1, 2016, if you are using a compound medication in which the primary ingredient is no longer covered, then the compound medication will no longer be covered.

For a few of the excluded compound medications, there are commercially available products that don’t require a compounded product. Only your medical provider and you can determine a suitable alternative since it is often difficult to determine the condition for which a compound medication is being prescribed. **If you continue to use the affected compound medications, you will pay the full retail price if you refill that prescription starting January 1, 2016.**

Please note that not all compounded prescriptions are being excluded from coverage. There is still an inclusion list of compound ingredients that will remain covered and are considered appropriate. For example, certain pediatric compounds remain covered.

If you are currently taking or are prescribed a compound medication, you can call Express Scripts Member Services at 1-800-987-8368 to verify if your medication is covered or excluded. After January 1, 2016, you can also go to the Express Scripts website at www.express-scripts.com and search for your medication to verify the coverage status.
PCSK9 Inhibitor Drug Class
New Prior Authorization Program

The FDA has approved the first formulas in a new class of cholesterol-lowering maintenance drugs called PCSK9 inhibitors. These new drugs are self-injectable specialty medications. Although studies are still underway, PCSK9 inhibitors may be used alone or in combination with current statin drugs to further lower the hardest-to-treat elevated cholesterol levels for patients who cannot tolerate any statin drug. This new generation of injectable biologics could offer an alternative for statin-intolerant patients.

While these new drugs will offer an alternative to statins, they may not be right for everyone. In addition, these drugs have the potential to drastically increase prescription drug costs under our High Deductible Health Plan for both you and Chevron.

In an effort to provide appropriate access to this new class of drugs while protecting plan costs, Express Scripts started the Cholesterol Care Value Program. This is a separate prior authorization program designed specifically for the new PCSK9 inhibitor drug class. This prior authorization program features:

- **A clinical review process by a dedicated clinical team.** With every new request for PCSK9 inhibitors, a dedicated Express Scripts clinical team, with pharmacists who specialize in cardiovascular disease, will employ a robust clinical review, which includes collecting clinical documentation and holding discussions with your physician, before approving your use of a PCSK9 inhibitor.

- **Enhanced care for patients starting PCSK9s.** If you’re changing therapy, you will automatically receive assistance and education from the Cholesterol Care team at Accredo, the Express Scripts specialty pharmacy. Accredo, will initially dispense three, 30-day prescriptions to ensure therapy tolerance before moving to a 90-day fill.

If you have questions, contact Express Scripts Member Services at **1-800-987-8368.**
Chevron High Deductible Health Plan

Overview of the Plan

The Chevron Corporation High Deductible Health Plan, hereafter referred to as the HDHP, is a preferred provider organization (PPO) health plan that Chevron sponsors for eligible employees. This plan includes the following components:

- Medical coverage, with UnitedHealthcare (UHC) as the claims administrator.
- Prescription drug coverage, with Express Scripts as the claims administrator.

In addition, if you enroll in the High Deductible Health Plan you are also automatically enrolled in the Vision Program for basic vision coverage with VSP.

U.S.-payroll resident expatriates and non-U.S.-payroll expatriates working in the United States are not eligible for the HDHP. U.S.-payroll resident expatriate employees may be eligible under the Global Choice Plan (U.S.-Payroll Expatriates). This plan is described in the Global Choice Plan (U.S.-Payroll Expatriates) summary plan description. Eligible expatriate employees working in the U.S. are covered under the Global Choice Plan (Expatriates in the U.S.). This plan is described in the Global Choice Plan (Expatriates in the U.S.) summary plan description. Go to hr2.chevron.com for both of these summary plan descriptions.

Note: Depending on where you live, you may be eligible for a medical health maintenance organization (HMO) plan. If you choose an HMO for your medical coverage, review the Medical and Dental HMO summary plan description. That SPD gives you information about eligibility, participation and your legal rights. For information about covered services or a list of HMO providers, contact your HMO.
High Deductible Health Plan Overview

- The plan is a preferred provider organization (PPO) plan. This means that the plan has a network of health care providers available in many locations. Higher benefits are paid when you receive care from a network provider. You always have the option of using an out-of-network provider, but plan benefits are lower if you do.

- With the HDHP you pay a low monthly premium in exchange for a high deductible. There is one combined deductible for medical, prescription drugs, mental, health and substance abuse services.

- You generally must satisfy the deductible with money out of your own pocket before the HDHP begins to share the cost of covered health care services through coinsurance.

- Certain preventive care services as specified under the Affordable Care Act (ACA) are covered at 100% and not subject to the HDHP deductible.

- The HDHP is a health savings account-compatible plan. If you are eligible to establish a health savings account (HSA), you can choose to use an HSA to pay for deductibles and out-of-pocket expenses. (Note: HDHP participants cannot participate in the Health Care Spending Account Plan).

- A feature of the plan is the out-of-pocket maximum, which limits your out-of-pocket costs.
Eligible Employees

This section provides information about benefit plan eligibility rules for you and your dependents.

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

Note: U.S.-payroll resident expatriates and non-U.S.-payroll expatriates working in the United States are not eligible for the HDHP. U.S.-payroll resident expatriates should refer to the Global Choice Plan (U.S.-Payroll Expatriates) summary plan description for information about health coverage. Non-U.S.-payroll expatriates working in the United States should refer to the Health Benefits for Expatriates in the U.S. summary plan description for information about health coverage.

Eligible Employees

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

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

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

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

You're a professional intern.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Enrolled as an eligible employee.
- Enrolled as an eligible retiree.
- On active duty in the armed forces of any state, country or international authority.
- If both you and your domestic partner are eligible employees or eligible retirees, each of you can enroll for individual coverage, or one of you can cover the other as a dependent. However, only one of you can enroll all of your children for coverage.
Eligible Children and Other Dependents
You can enroll a dependent child for coverage if he or she is all of the following:

- You or your spouse's/domestic partner's natural child, stepchild, legally adopted child, foster child, or a child who has been placed with you or your spouse/domestic partner for adoption.

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

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

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

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

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

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

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

Before your child can be enrolled, you may be required to provide proof of his or her eligibility.
Qualified Medical Child Support Order (QMCSO)

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

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

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

This section provides important information about participation in the HDHP.

**A Snapshot of What to Do When**
The following chart highlights when and how to enroll in the following plans.

<table>
<thead>
<tr>
<th>Plan</th>
<th>When to Enroll</th>
<th>How to Enroll</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Deductible Health Plan (HDHP)</strong></td>
<td>You can enroll yourself and your eligible dependents at any of the following times:</td>
<td>To enroll, contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). Be sure to complete and turn in any forms sent to you with your confirmation statement.</td>
</tr>
<tr>
<td>(includes prescription drug coverage)</td>
<td>• During your first 31 days on the job, if you’re eligible.</td>
<td>Before a dependent’s enrollment is processed, you may be required to provide proof of his or her eligibility (that is, a marriage license, a birth certificate or adoption papers). In addition, before you can enroll your domestic partner for medical plan coverage, you must file a notarized <em>Chevron Affidavit of Domestic Partnership (F-6)</em> form. To request a form, call the HR Service Center 1-888-825-5247 (610-669-8595 outside the U.S.).</td>
</tr>
<tr>
<td></td>
<td>• During open enrollment.</td>
<td>If you don’t enroll your eligible dependents at the same time you enroll yourself, you can enroll them during any open enrollment period or within 31 days of the date they first become eligible (for example, within 31 days of a qualifying life event).</td>
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<tr>
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<td>• Within 31 days of a qualifying life event.</td>
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<td><strong>Note:</strong> If you enroll in the High Deductible Health Plan you are automatically enrolled in the Vision Program for basic vision coverage with VSP.</td>
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<tr>
<td></td>
<td><strong>Note:</strong> To be eligible for the Mental Health and Substance Abuse Plan, your dependents must be enrolled in one of the Chevron-sponsored medical plans.</td>
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<tr>
<td><strong>Before-Tax Contribution Plan</strong></td>
<td>If you enroll in a health plan to which Chevron contributes, you’re automatically enrolled to have before-tax deductions for any medical and dental plans.</td>
<td>Not applicable for medical and dental, unless you elect not to enroll. If you don’t want to enroll, decline before-tax participation before your health plan coverage begins by contacting the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).</td>
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</table>
Before-Tax vs. After-Tax Contributions

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

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

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

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

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

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

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

The one exception to imputed federal income to you is if your domestic partner and/or his or her children (unless they are your natural or adopted children — in which case, they are treated just as any other children of an employee) qualify as your dependent as defined in Internal Revenue Code section 152 and you are able to claim them as a dependent on your federal income tax return.
If one of the following applies to you then you may not be subject to imputed income for state tax purposes:

- You live in California and meet all of the requirements of the California Family Code section 297 definition of a domestic partner, including the requirement to have registered your domestic partner with the Secretary of State’s office. For more information, visit the California Domestic Partnership website at www.ss.ca.gov/business/sf/sf_dp.htm. If you reside in California, you will be exempt from imputed income if you report that your domestic partner meets the state’s requirement of a tax dependent and you report that you have registered your domestic partner or with the Secretary of State.

- You live in another state such as Oregon or the District of Columbia that recognizes domestic partnerships and you meet that state’s requirements to cover your domestic partner on a before-tax basis. Check with your tax advisor about the tax treatment of coverage.

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

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

<table>
<thead>
<tr>
<th>Plan</th>
<th>Types of Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Deductible Health Plan (HDHP)</strong> (includes prescription drug coverage)</td>
<td>• You can change your medical plan elections only:</td>
</tr>
<tr>
<td></td>
<td>− During open enrollment. Changes take effect the following January 1.</td>
</tr>
<tr>
<td></td>
<td>− During the year if you or a dependent qualify for special enrollment or have a qualifying life event.</td>
</tr>
<tr>
<td></td>
<td>• If you pay for your coverage on an after-tax basis, however, you can cancel your coverage or drop dependents from coverage at any time.</td>
</tr>
<tr>
<td><strong>Before-Tax Contribution Plan</strong></td>
<td>• You can change the tax status of your health plan contributions (before-tax to after-tax or vice versa) during any open enrollment. Changes take effect the following January 1. You can’t otherwise change your plan elections unless there’s a qualifying life event.</td>
</tr>
</tbody>
</table>

Midyear Changes
If you pay for your medical coverage on a before-tax basis, because of the plan’s tax advantages, the Internal Revenue Service (IRS) restricts your ability to make changes to your benefits after initial enrollment. In general, once you enroll for (or decline) coverage, your benefit elections stay in effect for the entire plan year. However, under certain circumstances, you can enroll for or change certain coverages during the year (for example, if you experience a qualifying life event that affects your, your spouse’s/domestic partner’s or your dependent’s eligibility for plan benefits).
Qualifying Life Events
You can change certain benefit elections during the plan year if you experience a qualifying life event that results in a loss or gain of eligibility under the plan for yourself, your spouse/domestic partner or your dependent children. Changes can be made to your medical and dental coverage as long as the changes are consistent with, and correspond to, the qualifying life event.

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

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

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

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

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

Special Enrollment Due to Loss of Other Coverage

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

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

Loss of eligibility includes a loss of coverage due to any of the following:

- Legal separation.
- Divorce.
- Death.
- Ceasing to be a dependent as defined by the terms of a plan.
- Termination of employment.
- Reduction in the number of hours of employment.

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

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

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

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

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

**Special Enrollment Due to New Dependent Eligibility**

You and your eligible dependents can enroll in the plan (subject to certain conditions) if you acquire a dependent through marriage or formation of a new domestic partnership, birth, adoption or placement for adoption. You and your dependents must request special enrollment in writing no later than 31 days from the date of marriage, the date all of the requirements set forth in the *Chevron Affidavit of Domestic Partnership (F-6)* form are first met, birth, adoption or placement for adoption. The conditions that apply are as follows:

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

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

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

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

- **Effective date of coverage**:
  - Upon marriage: On the first day of the month coinciding with or following the date of marriage.
  - Upon formation of a domestic partnership: On the first day of the month coinciding with or following the date all of the requirements of the *Chevron Affidavit of Domestic Partnership (F-6)* form are first met.
  - Upon birth: On the date of the dependent’s birth.
  - Upon adoption or placement for adoption: On the date of such adoption or placement for adoption.
  - When adding a child (other than your own newborn or adopted child) to your coverage: On the first day of the month coinciding with or following the date the child first becomes your dependent.
Special Enrollment Due to the Children’s Health Insurance Program (CHIP)
The Children’s Health Insurance Program (CHIP) Reauthorization Act of 2009 extends and expands the State Children’s Health Insurance Program (SCHIP). The Act establishes special enrollment rights for employees and their dependents that are eligible for, but not enrolled in coverage under an employer-provided group health plan (such as the Chevron health plans). You and your dependents are eligible to enroll for Chevron health coverage as long as you apply within 60 days of the date either of the following occurs:

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

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

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

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

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

<table>
<thead>
<tr>
<th>Plan</th>
<th>Participation Begins:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Deductible Health Plan (HDHP)</strong></td>
<td>• On your hire date, if you enroll in a medical plan within 31 days of your hire date.</td>
</tr>
<tr>
<td>(includes prescription drug coverage)</td>
<td>• On the day you first become eligible, if you enroll in a medical plan within 31 days of the date you first become eligible.</td>
</tr>
<tr>
<td>Employee Coverage</td>
<td>• The day you acquire a dependent child, if you enroll within 31 days of the birth or the earlier of the date of adoption or placement for adoption.</td>
</tr>
<tr>
<td></td>
<td>• On the first day of the month coinciding with or following the date of your marriage, if you enroll within 31 days of your marriage.</td>
</tr>
<tr>
<td></td>
<td>• On the first day of the month coinciding with or following the date all of the requirements listed on the Chevron Affidavit of Domestic Partnership are first met, if you enroll within 31 days of first meeting the requirements listed on the Chevron Affidavit of Domestic Partnership.</td>
</tr>
<tr>
<td></td>
<td>• The following January 1, if you enroll in a medical plan during the open enrollment period.</td>
</tr>
<tr>
<td><strong>High Deductible Health Plan (HDHP)</strong></td>
<td>• On the same day your coverage begins, if you enroll yourself and your dependents at the same time.</td>
</tr>
<tr>
<td>(includes prescription drug coverage)</td>
<td>• On the date of birth, if you enroll a newborn child within 31 days of the date he or she is born.</td>
</tr>
<tr>
<td>Dependent Coverage</td>
<td>• On the date of adoption or on the date the child is placed with you for adoption (if earlier), if you enroll the child within 31 days.</td>
</tr>
<tr>
<td></td>
<td>• On the first day of the month coinciding with or following the date he or she becomes eligible, if you enroll a new spouse/domestic partner, child or stepchild (other than a newborn or newly adopted child) within 31 days.</td>
</tr>
<tr>
<td></td>
<td>• The following January 1, if you enroll in a medical plan during the open enrollment period.</td>
</tr>
<tr>
<td><strong>Before-Tax Contribution Plan</strong></td>
<td>• Generally at the same time as your participation in any one of the health plans.</td>
</tr>
<tr>
<td></td>
<td>• The following January 1, if you enroll in the plan during the open enrollment period.</td>
</tr>
</tbody>
</table>
When Participation Ends

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

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

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

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

A Snapshot of When Coverage Ends

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

<table>
<thead>
<tr>
<th>Plan</th>
<th>Participation Ends When:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Deductible Health Plan (HDHP)</strong></td>
<td>- You or your dependent is no longer eligible. Coverage ends on the last day of the month.</td>
</tr>
<tr>
<td><em>(includes prescription drug coverage)</em></td>
<td>- You cancel coverage or stop making required contributions. Coverage for you and your dependents ends on the last day of the month for which contributions were received.</td>
</tr>
<tr>
<td></td>
<td>- You move out of the service area of your current medical plan and you must change to a plan offered where you live. New coverage takes effect on the first day of the following month.</td>
</tr>
<tr>
<td></td>
<td>Coverage for you and your dependents also ends after 31 days of the following types of leave:</td>
</tr>
<tr>
<td></td>
<td>• Personal Leave Without Pay.</td>
</tr>
<tr>
<td></td>
<td>• Leave for educational reasons.</td>
</tr>
<tr>
<td></td>
<td>• Long Union Business Leave (unless you elect to pay 100% of the cost of continued coverage).</td>
</tr>
<tr>
<td></td>
<td>If you or a dependent is hospitalized at the time coverage under the HDHP ends, benefits for charges incurred in the hospital can be paid until you or your dependent leaves the hospital.</td>
</tr>
<tr>
<td>Plan</td>
<td>Participation Ends When:</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Before-Tax Contribution</td>
<td>• As a result of a qualifying life event, you stop participating in all of the health plans to which Chevron requires you to contribute.</td>
</tr>
<tr>
<td>Plan</td>
<td>• You elect to make contributions on an after-tax basis (participation ends on the following December 31).</td>
</tr>
<tr>
<td></td>
<td>• You transfer to a company that doesn’t participate in the High Deductible Health Plan (HDHP).</td>
</tr>
<tr>
<td></td>
<td>• You no longer receive a paycheck from Chevron and, as a result, you’re unable to make before-tax contributions.</td>
</tr>
<tr>
<td></td>
<td>• You’re no longer eligible to participate because of a plan change, a change in your employment status or other reasons.</td>
</tr>
<tr>
<td></td>
<td>• The plan is terminated or your employer stops participating in the plan.</td>
</tr>
</tbody>
</table>

**What Happens if You Die**

If you die, your enrolled dependents are eligible for either continuation coverage or retiree and survivor coverage. For more information, see the Continuation Coverage and COBRA Coverage section and the Retiree and Survivor Coverage section under Administrative Information.
How Much You Pay for Coverage

You and Chevron currently share the cost of your medical plan, which includes prescription drug coverage (Prescription Drug Program). Your cost for coverage depends on the option you select and the number of dependents you cover. The cost of coverage is communicated each year during open enrollment. For detailed information about Chevron’s contribution policy, see the Company Contributions for Medical Coverage section. For the most up-to-date costs for each plan, you can visit the Benefits Connection website at hr2.chevron.com or contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S).

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

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

With the High Deductible Health Plan, you have one combined deductible. Your combined deductible is the amount of covered medical, prescription drug, mental health, and substance abuse charges you pay for combined network and out-of-network care and services each calendar year before the plans begin paying their share of those charges. You must be ready to pay the full amount of the higher deductible up front before the HDHP pays any medical or prescription drug benefits and the Mental Health and Substance Abuse Plan pays for mental health and substance abuse benefits. However, certain preventive care, as specified by the Affordable Care Act, is not subject to the combined deductible. To find out which services are considered preventive care under the Affordable Care Act, you can call UHC or review the list online at www.uhcpreventivecare.com.

<table>
<thead>
<tr>
<th>Annual Deductible Amount</th>
<th>Combined for medical, prescription drugs, mental health and substance abuse.</th>
</tr>
</thead>
<tbody>
<tr>
<td>You Only</td>
<td>$2,650</td>
</tr>
<tr>
<td>You + One Adult</td>
<td>$5,300</td>
</tr>
<tr>
<td>You + Child(ren)</td>
<td>$5,300</td>
</tr>
<tr>
<td>You + Family</td>
<td>$7,950</td>
</tr>
</tbody>
</table>

The following expenses don’t count toward your deductible:

- Charges in excess of contracted fees for services provided by a network provider and charges in excess of allowable charges for services provided by an out-of-network provider.
- Charges for services or supplies that aren’t medically necessary.
- Charges for health care services and supplies that aren’t covered under the High Deductible Health Plan, the Prescription Drug Program and the Mental Health Substance Abuse Plan.
- Additional expenses you pay because you don’t follow the plan’s Health Care Review procedures.
- Additional expenses you pay above certain benefit limits, such as expenses for durable medical equipment.
- The difference you pay between the cost of the brand-name drug and its generic equivalent unless your Doctor provides the medical reason that the generic version of the drug will not work.
- The difference between the network pharmacy price and the out-of-network pharmacy price if you use an out-of-network pharmacy (or you don’t provide your ID card at a network pharmacy).

Each covered individual has a maximum deductible equal to the You Only deductible amount of $2,650. Once the covered individual reaches the You Only maximum deductible amount, then coinsurance will apply to the covered individual, meaning the plan pays its share of covered charges. For the You + One Adult, You + Child(ren) and You + Family coverage category levels, there is an overall maximum deductible amount for all covered participants that corresponds to the coverage category elected.
No more than the *You Only* deductible amount can be applied toward the family deductible for any one person to satisfy the *You + One Adult*, *You + Child(ren)* or *You + Family* deductible.

For example, if you choose the *You + Family* coverage tier, your annual deductible is satisfied when the family’s accumulation of deductibles reaches $7,950, with no more than $2,650 applied for each family member. Your family could meet the $7,950 deductible with charges of $2,650 for one member, $2,650 for a second member, $1,325 for a third member and $1,325 for a fourth member.
Out-of-Pocket Maximum

After you pay your HDHP combined annual deductible, the plan pays a percentage of covered charges for the care you need, and you pay any costs above the amount paid by the plan. When you reach the out-of-pocket maximum, the HDHP and Mental Health and Substance Abuse plans begin to pay 100 percent of the allowed amount for covered health care, mental health and substance abuse services for the calendar year.

The Out-of-Pocket Maximum amount is the most you will have to pay out of pocket for covered health care services for the year. This amount is important because it protects you in the event you have a year with major health expenses. The deductible, coinsurance, eligible prescription drugs, mental health and substance abuse charges you pay generally apply toward one out-of-pocket maximum amount as listed in the chart below.

### Annual Out-of-Pocket Amount

*Combined for medical, prescription drugs, mental health and substance abuse.*

<table>
<thead>
<tr>
<th>Coverage Tier</th>
<th>Maximum Out-of-Pocket Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>You Only</td>
<td>$5,000</td>
</tr>
<tr>
<td>You + One Adult</td>
<td>$9,000</td>
</tr>
<tr>
<td>You + Child(ren)</td>
<td>$9,000</td>
</tr>
<tr>
<td>You + Family</td>
<td>$12,900</td>
</tr>
</tbody>
</table>

Each covered individual has a maximum out-of-pocket amount equal to the You Only out-of-pocket maximum amount. Once the covered individual reaches the You Only out-of-pocket maximum amount, then the plan pays 100 percent of the allowed amount for covered health care services applicable to that individual. For the You + One Adult, You + Child(ren) and You + Family coverage category levels, there is an overall maximum out-of-pocket amount for all covered participants that corresponds to the coverage category elected. No more than the You Only amount can be applied for any one person to satisfy the You + Child(ren) or You + Family out-of-pocket maximum.

For example, if you choose the You + Family coverage tier, your annual out-of-pocket maximum is met when the family’s accumulation of out-of-pocket costs reaches $12,900, with no more than $5,000 applied for each family member. Your family could meet the $12,900 maximum limit with charges of $5,000 for one member, $5,000 for a second member, $1,450 for a third member and $1,450 for a fourth member.
The following expenses do not count toward the out-of-pocket maximum amount and are not part of the 100 percent coverage you receive after reaching your out-of-pocket maximums:

- Charges in excess of contracted fees for services provided by network providers and charges in excess of allowable charges for services provided by out-of-network providers.
- Charges for services or supplies that aren't medically necessary.
- Charges for services or supplies that aren't covered under the HDHP, the Prescription Drug Program and the Mental Health Substance Abuse Plan.
- Additional expenses you pay because you don’t follow the plan’s Health Care Review procedures.
- Additional expenses you pay above certain benefit limits, such as expenses for durable medical equipment.
- The difference between the network pharmacy price and the out-of-network pharmacy price, if you use an out-of-network pharmacy (or you don't provide your ID card at a network pharmacy).
- The additional coinsurance amount you pay when you go to a retail network pharmacy after the first refill of a prescription for maintenance medication.
Wellness Programs

The Omnibus Health Care Plan (which includes the High Deductible Health Plan) permits wellness programs to be offered under the terms and conditions established by Chevron. To learn about these wellness programs, see the Wellness Programs summary plan description.
Health Support

Nurseline
UnitedHealthcare offers the NurselineSM to HDHP and Medical PPO members. Experienced, registered nurses are available any time, day or night – 24 hours a day, seven days a week – to answer your health questions and concerns. NurseLine gives you another way to access health information. By calling the same number, you can listen to one of the Health Information Library’s over 1,100 recorded messages, with over half in Spanish. NurseLine is available to you at no additional cost. To use this service, call the number on the back of your ID card.

With NurseLine, you also have access to nurses online. To use this service, log onto www.myuhc.com and click Live Nurse Chat in the top menu bar. You'll be connected with a registered nurse who can answer your general health questions any time – 24 hours a day, seven days a week. You can also request an e-mail transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of calling NurseLine.

Nurse Advisor Team
A team of registered nurses with UHC is available as part of your plan benefit. The Nurse Advisor team is dedicated solely to Chevron.

You can call a nurse advisor with questions or concerns for health matters big and small. A nurse advisor can help you with condition management (for example, diabetes or asthma), understanding an illness, an upcoming hospitalization, major surgery or treatment options.

In some situations, you might receive a call from a Nurse Advisor directly. Your Nurse Advisor will be alerted to your condition based on your medical and prescription drug claims. Your Nurse Advisor is there to help answer your questions and support you in managing your condition. You may even receive educational materials and individualized support for your condition.

They can also help you understand and follow your doctor’s treatment plan and self-care suggestions, provide you with educational materials and individualized support, find doctors or other health care professionals in the network as well as connect you with community resources.

The Nurse Advisor Team currently provides support in the following areas:

- Case Management
- Treatment Decision Support
- Maternity Support Program
- Transplant Resource Services
- Cancer Support Program
- Kidney Resource Program
- Healthy Back Program
- Congestive Heart Failure
- Asthma
- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disorder (COPD)
- Diabetes

You can contact a nurse 24 hours a day, seven days a week at 1-800-654-0079. Choose the Speak with a Nurse option. If you would like more information about nurse advisor services you can also visit UHC’s website at www.myuhc.com, login to your account, and then scroll down to the Ask a Nurse section on your home screen.
Medical Coverage

UnitedHealthcare (UHC) is the claims administrator of medical benefits under the High Deductible Health Plan. You and your eligible dependents have this medical coverage if you are enrolled in the High Deductible Health Plan. This section describes the medical benefits under the plan.
How the Plan Works

When you need health care, you can go to a PPO network provider or to a provider who isn’t in the network. The choice is yours. To get a list of network providers near you call 1-800-654-0079 or visit the website at [www.myuhc.com](http://www.myuhc.com).

Networks

It’s your responsibility to ensure that you use network providers if you want to receive the network reimbursement amount.

**If You Go to a PPO Network Provider**

Generally, the plan pays higher benefits for most kinds of care when you go to a PPO network provider. Network providers charge discounted rates for covered services they provide to plan members, and plan benefits are based on these discounted rates.

Generally, you don’t have to file a claim form when you go to a PPO network provider. Your provider files the claim for you. UnitedHealthcare sends you an Explanation of Benefits (EOB) statement that shows how much you owe for the care you received. Your provider bills you for that amount, unless you pay your portion of the charge when you receive the service.

**If You Go to an Out-of-Network Provider**

Generally, the plan pays lower benefits for most kinds of care when you go to an out-of-network provider, and plan benefits are based on allowable charges. If you go to an out-of-network provider, you first pay for the services and supplies you receive. You must then file a claim for benefits, and you then are reimbursed according to the plan’s out-of-network benefit provisions. You are responsible for any charges above the allowable charge amount.

UnitedHealthcare administers claims and provides Health Care Review services for the plan. You or your doctor may need to contact UnitedHealthcare’s Health Care Review Program to qualify for full plan benefits for certain kinds of care.

**Special Provision for Alaska Employees**

Eligible participants (and their covered dependents) with a permanent home address in Alaska will receive the network level of coverage, applied to the billed charges for services received in Alaska. For instance, if a participant who resides in Alaska incurs covered charges in Alaska that are generally covered on an in-network basis at 90 percent of the contracted fees, such charges will be covered at 90 percent of billed charges. Services received outside of Alaska will be reimbursed based on their network status, either in-network or out-of-network. For example, if you reside in Alaska and you obtain services on a business trip or vacation to Houston, Texas and use an out-of-network provider for an office visit, the plan will reimburse 80 percent of allowable charges. This provision does not apply to vision or prescription drug benefits.
If You Go to Certain UnitedHealthcare Out-of-Network Providers
The HDHP offers a discount if you use an out-of-network hospital, medical facility, doctor or other health care professional who is affiliated with MultiPlan. With this discount, your out-of-pocket costs are mid-level — higher than if you use network providers, but lower than if you use other unaffiliated out-of-network providers.

Here’s how it works. When you use an out-of-network provider affiliated with MultiPlan, out-of-network benefit rates apply. However, these rates apply to a discounted fee negotiated between UnitedHealthcare and the preferred out-of-network provider, MultiPlan. Because the charge is discounted, your portion is less, too. Also, like network providers, MultiPlan providers do not bill you for the amount that exceeds the discounted charge (certain exceptions apply).

To find an out-of-network provider affiliated with MultiPlan, call 1-800-654-0079 or access the website at www.myuhc.com. Select Physicians and Facilities and then select Non-Network Savings (To use the provider search tool for the Non-Network Savings feature, you must be a registered user and log in to the myuhc.com website.)

Pre-Service Review
UHC may need to review proposed hospitalization and other specified procedures to confirm that they’re medically necessary and appropriate for the condition being treated. Please refer to the Health Care Review section to determine which services require prior approval. Notification, or in some cases approval by UHC, is required before full plan benefits can be paid for some kinds of care.

Claims Administrator
Medical benefits claims under the HDHP are administered by a claims administrator – UnitedHealthcare – in all states except Hawaii where the HDHP is not offered to employees.

UnitedHealthcare reviews, approves (or denies) and processes all claims other than those for outpatient prescription drugs, mental health and substance abuse and for vision care. They also manage the PPO network of providers. In addition, their staff informs plan members which charges are covered and which aren’t covered under the plan.

For a list of UHC PPO network providers, you can log on to the website at www.myuhc.com. You can reach UnitedHealthcare’s NurseLine at 1-800-654-0079, option 3. You can reach Personal Health Support (for Health Care Review) at 1-800-654-0079 between 7 a.m. and 5 p.m. Pacific time, Monday through Friday.
What the Plan Pays

This section provides information about the network and out-of-network benefits for covered services. To receive the full benefits for some kinds of care, you have to follow Health Care Review procedures for the HDHP. The plan also includes a Prescription Drug Program. For more information, see Health Care Review and Prescription Drug Program in this section.

Acupuncture

<table>
<thead>
<tr>
<th>Network</th>
<th>90% of contracted fees after deductible for office visits up to a maximum of 20 visits per calendar year (combined network and out-of-network visits).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Network</td>
<td>80% of allowable charges after deductible for office visits up to a maximum of 20 visits per calendar year (combined network and out-of-network visits).</td>
</tr>
</tbody>
</table>

The plan pays for acupuncture services provided by a licensed or certified doctor, chiropractor, or acupuncturist, acting within the scope of that license or certification, to treat chronic pain when another method of pain management has failed, or nausea that is related to surgery, pregnancy or chemotherapy, up to a maximum of 20 visits (combined network and out-of-network visits) per calendar year.

Allergy Treatment

<table>
<thead>
<tr>
<th>Network</th>
<th>90% of contracted fees after deductible.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Network</td>
<td>80% of allowable charges after deductible.</td>
</tr>
</tbody>
</table>

The plan helps pay for allergy testing and treatment, including the injection and cost of allergy serum.

Ambulance Transportation

<table>
<thead>
<tr>
<th>Emergency</th>
<th>Network: 90% of contracted fees after deductible.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Out-of-network: 90% of billed charges after deductible.</td>
</tr>
<tr>
<td>Nonemergency</td>
<td>Network: 90% of contracted fees after deductible.</td>
</tr>
<tr>
<td></td>
<td>Out-of-network: 80% of allowable charges after deductible.</td>
</tr>
</tbody>
</table>

The plan pays for emergency ambulance (land or air) transportation by a licensed ambulance service to the nearest hospital where emergency health services can be performed. Also covered, with authorization, is nonemergency, but medically necessary, transportation by ambulance, regularly scheduled airline, railroad or air ambulance to the nearest medical facility qualified to give the required treatment.
Birth and Newborn Charges

<table>
<thead>
<tr>
<th>Network</th>
<th>100% of contracted fees, no deductible, for doctor services; 90% of contracted fees after deductible for facility charges.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Network</td>
<td>80% of allowable charges, no deductible, for doctor services; 80% of allowable charges after deductible for facility charges.</td>
</tr>
</tbody>
</table>

The plan covers delivery and subsequent doctor charges for a healthy newborn including breastfeeding support, supplies and counseling. Covered charges include:

- Hospital room and board for you and your baby (the healthy baby is not subject to his or her own deductible while initially in the hospital after delivery).

- Inpatient care for you.

- Inpatient well-baby care (including routine nursing care, pediatrician services and miscellaneous tests).

- Services provided by doctors and nurses during delivery.

- Hospital services and supplies.

- Licensed birthing center (limited to $1,000 per pregnancy).

- A circumcision performed within 28 days of the birth, whether performed in or out of the hospital.

You don’t have to get advance approval from UnitedHealthcare to have your baby in a hospital. However, you’ll need to notify UnitedHealthcare to make sure you qualify for the full plan benefits if your doctor thinks you’ll have to stay in the hospital:

- More than 48 hours after a normal delivery.

- More than 96 hours after a cesarean delivery.

The following applies for both network and out-of-network childbirth services. No approval or preauthorization is needed from UnitedHealthcare for maternity admissions. In accordance with the Newborns’ and Mothers’ Health Protection Act of 1996, the plan may not restrict benefits for a mother’s or newborn child’s hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, the law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).
**Birthing Centers**

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<thead>
<tr>
<th></th>
<th>Network</th>
<th>Out-of-Network</th>
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<tbody>
<tr>
<td><strong>Network</strong></td>
<td>90% of contracted fees after deductible, to a maximum of $1,000 per pregnancy.</td>
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</tr>
<tr>
<td><strong>Out-of-Network</strong></td>
<td>80% of allowable charges after deductible, to a maximum of $1,000 per pregnancy.</td>
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</table>

The plan covers maternity- and pregnancy-related services provided at an approved birthing center, such as room and board and miscellaneous supplies and services, including anesthetics and their administration.

A birthing center is a facility that operates under the license of a hospital and provides a home-like setting under a controlled environment for the purpose of childbirth.

If you choose a midwife or nurse-midwife who is supervised by a network doctor, these services are covered at 90 percent of contracted fees after the deductible. If the midwife is supervised by an out-of-network doctor, services are covered at 80 percent of allowable charges after the deductible. Home delivery is not covered under the plan.

**Chemotherapy Treatment**

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<tr>
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<th>Network</th>
<th>Out-of-Network</th>
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<tbody>
<tr>
<td><strong>Network</strong></td>
<td>90% of contracted fees after deductible.</td>
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<tr>
<td><strong>Out-of-Network</strong></td>
<td>80% of allowable charges after deductible.</td>
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Effective June 1, 2015, UnitedHealthcare determines coverage for outpatient chemotherapy cancer treatments using the National Comprehensive Cancer Center (NCCN®) Guidelines®. The NCCN is a not-for-profit alliance of 25 of the world's leading cancer centers devoted to patient care, research and education. Drugs that meet NCCN criteria are approved; those that do not are denied and the network providers are financially responsible. Providers can contact UHC for prior approval, but are not required to do so.

**Chiropractic Care**

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<thead>
<tr>
<th></th>
<th>Network</th>
<th>Out-of-Network</th>
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<tbody>
<tr>
<td><strong>Network</strong></td>
<td>90% of contracted fees after deductible for office visits or treatment in an outpatient facility; up to a maximum of 20 visits per calendar year (combined network and out-of-network visits).</td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Network</strong></td>
<td>80% of allowable charges after deductible for office visits or treatment in an outpatient facility; up to a maximum of 20 visits per calendar year (combined network and out-of-network visits).</td>
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</table>

The plan covers the services of a doctor or chiropractor for the detection or correction (manipulation), by manual or mechanical means, of structural imbalance or distortion in the spine.

The plan pays benefits only for therapy services given by a licensed or certified provider acting within the scope of that license or certification.
Clinical Trials – Office Visits*

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<tr>
<td><strong>Network</strong></td>
<td>90% of contracted fees after deductible.</td>
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<tr>
<td><strong>Out-of-Network</strong></td>
<td>80% of allowable charges after deductible.</td>
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Clinical Trials – Hospital Care* (inpatient and outpatient)

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<tr>
<td><strong>Network</strong></td>
<td>90% of contracted fees after deductible.</td>
</tr>
<tr>
<td><strong>Out-of-Network</strong></td>
<td>80% of allowable charges after deductible.</td>
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</table>

*Review the Hospital Care and Office Visit tables in this section for additional coverage information.

As required by the Patient Protection and Affordable Care Act, the plan provides coverage for *certain routine patient costs incurred during participation* in an approved clinical trial for:

- Cancer or other life-threatening diseases or conditions.
- Cardiovascular disease (cardiac/stroke) which is not life threatening for which the claims administrator determines a clinical trial meets the plan’s qualifying clinical trial criteria.
- Surgical musculoskeletal disorders of the spine, hip and knees which are not life threatening for which the claims administrator determines a clinical trial meets the plan’s qualifying clinical trial criteria.
- Other diseases or disorders which are not life threatening for which the claims administrator determines a clinical trial meets the plan’s qualifying clinical trial criteria.

For more information about what services are considered routine patient costs and what qualifies as an approved clinical trial, contact Personal Health Support at 1-800-654-0079.

Cochlear Implants

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<tr>
<td><strong>Network</strong></td>
<td>90% of contracted fees after deductible.</td>
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<tr>
<td><strong>Out-of-Network</strong></td>
<td>80% of allowable charges after deductible.</td>
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</tbody>
</table>

The plan pays covered charges for services and supplies, including implantable components, for bilateral or unilateral cochlear implantation where required due to profound prelingual, perilingual or postlingual bilateral sensorineural hearing loss in children and when due to profound postlingual bilateral sensorineural hearing loss in adults (This includes adults who were initially diagnosed with prelingual or perilingual bilateral sensorineural hearing loss and who have progressed to severe to profound postlingual bilateral sensorineural hearing loss). Cochlear implantation not described above, including unilateral or bilateral cochlear implants in adults when due to prelingual or perilingual sensorineural hearing loss, and cochlear hybrid implants, are not covered.
The external components for covered implantation (such as a speech processor, microphone, and transmitter coil) are considered durable medical equipment (DME) – see the Durable Medical Equipment chart.

The plan will pay only for a single purchase (including repair or replacement) for cochlear implants once every three years.

### Colonoscopy

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<tbody>
<tr>
<td><strong>Network</strong></td>
<td>100% of contracted fees for preventive colonoscopies; 90% of contracted fees after deductible for routine colonoscopies.</td>
</tr>
<tr>
<td><strong>Out-of-Network</strong></td>
<td>100% of allowable charges for preventive colonoscopies; 80% of allowable charges after deductible for routine colonoscopies.</td>
</tr>
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</table>

The plan covers colonoscopies recommended by your physician, including those performed as a preventive screening.

General anesthesia for this procedure is not covered unless determined by UnitedHealthcare to be medically necessary.

### Dental Care

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<tr>
<td><strong>Network</strong></td>
<td>90% of contracted fees after deductible.</td>
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<tr>
<td><strong>Out-of-Network</strong></td>
<td>80% of allowable charges after deductible.</td>
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</tbody>
</table>

The plan helps pay for the following kinds of dental care and oral surgery only:

- Dentists’ charges for the repair or initial replacement of sound, natural teeth that are damaged or lost as a result of an accident other than a chewing injury. Initial contact with the dentist or physician must occur within 72 hours and services must begin within three months and be completed within 12 months of the date of the accident. (You must notify UHC’s Personal Health Support before receiving services in a hospital.).

- Oral surgery to correct fractures and dislocations resulting from an accident. Services must begin within three months and be completed within 12 months of the date of the accident. (You must notify UHC’s Personal Health Support before receiving services in a hospital.).

- Oral surgery for tumors and cysts of the mouth, except for those caused by diseases of the teeth or gums.

- Oral surgery to control a medical condition other than TMJ, such as osteomyelitis, cleft palate, burns and orthognathic surgery, which are within the mouth but not tooth- or gum-related.

- Facility and anesthesia charges for any of the covered procedures or when necessary due to an underlying medical condition.
**Surgical TMJ Treatments**
The plan helps pay for oral surgery for treatment of temporomandibular joint dysfunction (TMJ).

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<tr>
<th>Network</th>
<th>90% of contracted fees after deductible.</th>
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<tbody>
<tr>
<td>Out-of-Network</td>
<td>80% of billed charges after deductible.</td>
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</table>

**Non-Surgical TMJ Treatments**

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<tr>
<th>Network</th>
<th>50% of contracted fees after deductible.</th>
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</thead>
<tbody>
<tr>
<td>Out-of-Network</td>
<td>50% of allowable charges after deductible.</td>
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</tbody>
</table>

The plan pays covered charges for certain kinds of nonsurgical TMJ treatments. This includes orthotic splints and certain other kinds of TMJ treatments, but not procedures, restorations or prostheses that permanently alter the bite.

**Emergency Services (within the U.S.)**

<table>
<thead>
<tr>
<th>Network</th>
<th>90% of contracted fees after deductible.</th>
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</thead>
<tbody>
<tr>
<td>Out-of-Network</td>
<td>90% of billed charges after deductible.</td>
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</table>

The plan pays covered charges for emergency room care, radiology, anesthesia and pathology services.

To make sure you qualify for full benefits, you or your doctor must notify UnitedHealthcare within two business days after an emergency hospital admission. If you don’t follow the Health Care Review procedures, benefits paid for your emergency care may be reduced to 60 percent of covered charges.
Family Planning and Infertility Services

<table>
<thead>
<tr>
<th>Network</th>
<th>90% of contracted fees after deductible.</th>
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<tbody>
<tr>
<td>Out-of-Network</td>
<td>80% of allowable charges after deductible.</td>
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</tbody>
</table>

The plan helps pay covered charges for family planning and related services. These services include:

- The diagnosis and treatment of medical conditions that result in infertility, including expenses related to surgery and drug therapy.
- Artificial insemination.
- Vasectomy.
- Tubal ligation.
- Reversal of vasectomy or tubal ligation.
- Sperm preparation.
- Selection reduction in multiple births and abortions that are either medically necessary or elective.

In addition, the following services to facilitate a pregnancy are covered by the plan and are subject to an aggregate $5,000 lifetime maximum benefit:

- In vitro fertilization.
- Embryo transfer.
- Gamete intrafallopian transfer.
- Zygote intrafallopian transfer.
- Tubal ovum transfer.

Charges related to surrogate parents and charges incurred by a sperm or egg donor are not covered.

Included are doctor-prescribed contraceptives that require insertion by a doctor or significant doctor follow-up, such as injectable contraceptives, morning-after pills, implants (such as Depo-Provera or Levonorgestrel), IUDs, diaphragms, other removable devices and related office visits. Oral contraceptives are covered under the Prescription Drug Program. Over-the-counter supplies are not covered.
Gender Identity Disorder — Hospital Care* (inpatient and outpatient)

<table>
<thead>
<tr>
<th>Network</th>
<th>90% of contracted fees after deductible.</th>
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<tbody>
<tr>
<td>Out-of-Network</td>
<td>80% of allowable charges after deductible.</td>
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</table>

Gender Identity Disorder — Office Visits*

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<thead>
<tr>
<th>Network</th>
<th>90% of contracted fees after deductible.</th>
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</thead>
<tbody>
<tr>
<td>Out-of-Network</td>
<td>80% of allowable charges after deductible.</td>
</tr>
</tbody>
</table>

*Review the Hospital Care and Office Visit tables in this section for additional coverage information.

The plan pays benefits for the treatment of gender identity disorder for inpatient and outpatient benefits as follows below. **Before beginning treatment, you or your doctor must notify Personal Health Support at UHC** to request a Health Care Review at least five business days before you’re admitted to the hospital for network or out-of-network hospitalization The Plan pays Benefits for the treatment of Gender Identity Disorder/Dysphoria as follows:

- Continuous hormone replacement - hormones of the desired gender injected by a medical provider. Note. Coverage may be available for oral and self-injected hormones may be covered under the Chevron Corporation Prescription Drug Program, Supplement F to the Omnibus Plan.

- Genital surgery and surgery to change specified secondary sex characteristics (including thyroid chondroplasty, bilateral mastectomy, and augmentation mammoplasty).
  - The treatment plan must conform to the most recent edition of the World Professional Association for Transgender Health (WPATH), Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People; and
  - For irreversible surgical interventions, the patient must be age 18 years or older; and
  - Prior to surgery, the patient must complete 12 months of successful continuous full time real life experience in the desired gender.

- Laboratory testing to monitor the safety of continuous hormone therapy.

The Claims Administrator has specific guidelines regarding Benefits for Treatment of Gender Identity Disorder. Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.

**Important:** Certain patients will be required to complete continuous hormone therapy prior to surgery. In consultation with your doctor, this will be determined on a case-by-case basis through the prior authorization process.
Augmentation mammoplasty is allowed if your doctor prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role; and

**The following services are not covered under the plan:**

- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics.
- Sperm preservation in advance of hormone treatment or gender surgery.
- Cryopreservation of fertilized embryos.
- Voice modification surgery.
- Facial feminization surgery, including but not limited to: facial bone reduction, face “lift”, facial hair removal, and certain facial plastic procedures.
- Suction-assisted lipoplasty of the waist.
- Rhinoplasty (except if reconstructive criteria for rhinoplasty is met; Contact Personal Health Support at UHC for coverage details).
- Blepharoplasty (except if reconstructive criteria for blepharoplasty is met; contact Personal Health Support at UHC for coverage details).
- Surgical or hormone treatment on enrollees under 18 years of age.
- Surgical treatment not prior authorized by UnitedHealthcare.
- Drugs for hair loss or growth.
- Drugs for sexual performance or cosmetic purposes (except for hormone therapy described above).
- Voice therapy.
- Transportation, meals, lodging or similar expenses.

In addition, the following family planning services, when otherwise covered under the plan, are covered with respect to an individual who has had a gender reassignment only when typically provided to the individual’s current gender and not those typically provided to the individual’s former gender: in vitro fertilization, embryo transfer, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and tubal ovum transfer.
Hearing Aids

<table>
<thead>
<tr>
<th>Network</th>
<th>90% of contracted fees after deductible.</th>
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</thead>
<tbody>
<tr>
<td>Out-of-Network</td>
<td>90% of allowable charges after deductible.</td>
</tr>
</tbody>
</table>

The plan pays covered charges for hearing aids for dependent children who are under age 26, including bone anchored (BAHA) hearing aids when medically necessary. Hearing aids are covered up to a maximum of $5,000 once every 4 years. Coverage for cochlear implants is described in the Cochlear Implant section above.

**Hearing Aids:** Coverage includes the hearing aid device and fitting. Batteries and routine maintenance of the device are not covered.

**Bone Anchored Hearing Aids (BAHA):** Coverage for BAHA includes the actual hearing device as well as the surgery to attach or remove the device (surgery is covered under Surgical section below). Coverage for BAHA is limited to the following conditions:

- Craniofacial anomalies where abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity exists that would not be adequately remedied by a wearable hearing aid.

Home Health Care

<table>
<thead>
<tr>
<th>Network</th>
<th>90% of contracted fees after deductible, up to a maximum of 60 visits per calendar year (combined network and out-of-network visits).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Network</td>
<td>70% of allowable charges after deductible, up to a maximum of 60 visits per calendar year (combined network and out-of-network visits).</td>
</tr>
</tbody>
</table>

Any combination of network and out-of-network benefits is limited to 60 visits per calendar year. One visit equals four hours of skilled home health care services.

The plan pays covered charges for medical services provided in your home by a home health care agency. No benefits are payable for custodial care.

Services received from an approved home health care agency must be both of the following:

- Ordered by a doctor.
- Provided by or supervised by a registered nurse in your home or by a home health aide supervised by a registered nurse.

Benefits are available only when the home health care agency services are provided on a part-time, intermittent schedule and when skilled home health care is required.
Skilled home health care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- It is ordered by a doctor.
- It is not delivered for the purpose of assisting with activities of daily living, including, but not limited to, dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not custodial care.

UnitedHealthcare decides if skilled home health care is required by reviewing both the skilled nature of the service and the need for doctor-directed medical management. A service is not determined to be skilled simply because there is not an available caregiver.

**Hospice Care**

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<tr>
<th>Network</th>
<th>90% of contracted fees after deductible.</th>
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<tr>
<td>Out-of-Network</td>
<td>80% of allowable charges after deductible.</td>
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</table>

These benefits are payable whether covered care is provided in an approved hospice facility or in the patient’s home. To receive full plan benefits, you should notify UHC’s Personal Health Support before services begin.

Hospices offer an alternative to hospital care for the treatment of terminally ill patients. These programs also provide counseling for the families of the terminally ill.

To be eligible for the following hospice care benefits, the patient’s doctor must certify that the patient is terminally ill and has a life expectancy of six months or less. Hospice care must be ordered by a doctor and must be delivered or supervised by licensed technical or professional medical personnel. Coverage includes:

- Inpatient room and board accommodations, services and supplies.
- Part-time nursing care by or under the supervision of a registered nurse.
- Part-time or intermittent nursing care provided at the patient’s home by or under the supervision of a registered nurse furnished by an approved home health care agency.
- Part-time or intermittent home health aide services, consisting primarily of caring for the patient, that are provided by an approved home health care agency.
- Counseling services (for the patient and the patient's immediate family) by a licensed social worker or a licensed pastoral counselor.
Hospice — Bereavement Counseling

<table>
<thead>
<tr>
<th>Network</th>
<th>50% of contracted fees after deductible, for up to 15 visits.</th>
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<tbody>
<tr>
<td>Out-of-Network</td>
<td>50% of allowable charges after deductible, for up to 15 visits.</td>
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</table>

Bereavement counseling is available (for the patient’s immediate family members who are covered by the HDHP) from a licensed social worker or a licensed pastoral counselor within six months after the patient’s death.

Additional counseling services also may be available through the Mental Health and Substance Abuse Plan. Counseling services related to hospice care are not intended to address mental or nervous disorders.

Hospital Care (inpatient and outpatient)

<table>
<thead>
<tr>
<th>Network</th>
<th>90% of contracted fees after deductible.</th>
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</thead>
<tbody>
<tr>
<td>Out-of-Network</td>
<td>80% of allowable charges after deductible.</td>
</tr>
</tbody>
</table>

Preadmission testing and surgical testing for inpatient or outpatient surgery is covered at 90 percent of contracted fees or 80 percent of allowable charges, both after the deductible.

The plan covers charges for the following hospital services and supplies:

- Private room and board charges up to the hospital’s average semiprivate room rate (excludes charges for personal items such as newspapers, telephones, radios and TVs).
- Medical services and supplies provided while you’re receiving inpatient or outpatient care at a hospital.
- Care provided in hospital rooms designed for specialized care, such as operating rooms, intensive care units and emergency rooms.
- Tests and therapies provided while you’re an inpatient.

Charges for confinement in a non-acute-care section of an acute-care hospital, such as an outpatient surgery center or birthing center, will be covered at the level of coverage for that type of facility, not at the coverage level of the acute-care hospital.

To make sure you qualify for full hospitalization benefits, you or your doctor must notify UHC to request a Health Care Review three or more business days before you’re admitted to the hospital for network or out-of-network hospitalization or within two business days after an emergency admission. If you don’t follow the plan’s Health Care Review procedures, benefits paid for your hospital care (either network or out-of-network) are reduced to 60 percent of covered charges.
The following applies for both network and out-of-network childbirth services: No approval or preauthorization for maternity admissions is needed from UnitedHealthcare. In accordance with the Newborns’ and Mothers’ Health Protection Act of 1996, the plan may not restrict benefits for a mother’s or newborn child’s hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, the law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable). Note that authorization must be obtained from the UnitedHealthcare for a length of stay in excess of these periods. For a description of benefits, see the Birth and Newborn Charges chart under What the Plan Pays in this section.

**Lab Tests and X-Rays**

<table>
<thead>
<tr>
<th>Network</th>
<th>90% of contracted fees after deductible, regardless of where the service is performed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Network</td>
<td>80% of allowable charges after deductible, regardless of where the service is performed.</td>
</tr>
</tbody>
</table>

Benefits are paid only when lab tests and X-rays are requested or prescribed by a doctor.

**Medical Supplies and Equipment**

<table>
<thead>
<tr>
<th>Network</th>
<th>90% of contracted fees after deductible.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Network</td>
<td>80% of allowable charges after deductible.</td>
</tr>
</tbody>
</table>

The plan help pay covered charges for the purchase of needed medical supplies and equipment, including:

- Casts, splints, dressings, braces and crutches.
- Ostomy supplies.
- Intravenous (iv) infusion therapy supplies.
- Prosthetic devices, such as breast prostheses, artificial limbs and eyes to initially replace natural body parts, and their subsequent repair and replacement if they malfunction, limited to a single purchase of each type of prosthetic device once every three years.
- Initial pair of eyeglasses or contact lenses, including fitting, following surgery or accidental injury to the lens of an eye.
- Glucometers (the plan also pays covered charges for diabetic testing supplies, but under the Prescription Drug Program).
- Orthopedic shoes and needed modifications to the shoes, if shoes are part of a medically necessary brace.
- Durable medical equipment, including:
- Equipment to assist mobility, such as a standard wheelchair.
• A standard hospital-type bed.

• Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and mask).

• Delivery pumps for tube feeding (including tubing and connectors).

• Braces that stabilize an injured body part (including necessary adjustments to shoes to accommodate braces), but dental braces are excluded from coverage.

• Mechanical equipment necessary for the treatment of chronic or acute respiratory failure, but air conditioners, humidifiers, dehumidifiers, air purifiers, air filters and personal comfort items are excluded from coverage.

• External components (speech processor, microphone, and transmitter coil, for example) of covered cochlear implants.

If you rent durable medical equipment, plan benefits are based on rental charges up to the amount that would be paid to buy the equipment.

If you can prove that you have a long-term need for the equipment and that rental charges are expected to equal or exceed the purchase price of the equipment, the UnitedHealthcare may direct you to buy the equipment rather than rent it. You should notify UnitedHealthcare’s Personal Health Support prior to purchasing or renting durable medical equipment with a retail value or cumulative rental cost over $1,000. To receive benefits, the patient must purchase or rent the durable medical equipment from a network provider. The plan pays benefits only for a single purchase (including repair or replacement or both) of a type of durable medical equipment once every three years. The plan will pay only for the most cost-effective piece of equipment that would meet the patient’s functional needs.

Non-U.S. Medical Services
The plan will reimburse you at the out-of-network percentage level of billed charges after you meet the deductible for medically necessary treatments and services incurred outside the U.S. Emergency services will be reimbursed at the network percentage level of billed charges after you meet the deductible. Notification or authorization is not required for services received outside the U.S. However, the plan will not reimburse you for services and supplies that do not meet the definition of a covered charge or if the services and supplies were obtained outside the U.S. because you were or would be denied coverage for such services and supplies within the U.S.
Obesity Surgery
Generally, except where noted:

<table>
<thead>
<tr>
<th></th>
<th>90% of contracted fees after deductible.</th>
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<tbody>
<tr>
<td>Network</td>
<td></td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>80% of allowable charges after deductible.</td>
</tr>
</tbody>
</table>

Obesity surgery is covered only if there is a diagnosis of morbid obesity. Prior to the surgery you must notify UHC’s Personal Health Support.

Office Visits
Generally, except where noted:

<table>
<thead>
<tr>
<th></th>
<th>90% of contracted fees after deductible.</th>
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<tbody>
<tr>
<td>Network</td>
<td></td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>80% of allowable charges after deductible.</td>
</tr>
</tbody>
</table>

The plan pays covered charges for most medical office visits (visits to your doctor for diagnosis and treatment of sickness or injury or for a medical consultation).

The plan pays covered charges for office visits for preventive care as described in the Preventive Care chart under What the Plan Pays in this section. The plan also pays covered charges for surgical services or other invasive-type procedures performed in a doctor’s office, which are considered surgical by the American Medical Association (AMA) as described under Surgery in this section.

Organ and Tissue Transplants

<table>
<thead>
<tr>
<th></th>
<th>90% of contracted fees after deductible.</th>
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<tbody>
<tr>
<td>Network</td>
<td></td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>80% of allowable charges after deductible.</td>
</tr>
</tbody>
</table>

Prior to the transplant you must notify UHC’s Personal Health Support. The transplant must be done at a facility approved or designated by UnitedHealthcare. Supplies and services for the following organ or tissue transplants or multiple organ transplants are covered by the plan when ordered by a doctor:

- Bone marrow transplants, either from you or from a compatible donor, and peripheral stem cell transplants, with or without high-dose chemotherapy (not all bone marrow transplants meet the definition of medically necessary).
- Heart transplants.
- Heart-lung transplants.
- Lung transplants.
- Kidney transplants.
- Kidney-pancreas transplants.
- Liver transplants.
• Liver-small bowel transplants.
• Pancreas transplants.
• Small bowel transplants.
• Cornea transplants provided by a doctor at a hospital (cornea transplants need not be performed at an approved network transplant facility in order to receive network benefits).

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage. Charges for non-biologically-related donor searches for purposes of stem cell transplants are limited to $25,000 per transplant procedure. Charges for non-biologically-related donor searches for purposes of bone marrow transplants are limited to $25,000 per transplant procedure.

Certain procedures are covered only if there is accepted clinical evidence that the procedure is an effective means to treat your specific medical condition. You must notify UnitedHealthcare in advance. The plan does not cover any organ or tissue transplant if it is considered by generally recognized professionals or publications as experimental, investigative or unproven in the treatment of the specific medical condition.

**Transportation and Lodging**
Reimbursements of expenses for travel and lodging for the transplant recipient and a companion are available as follows:

• Plan reimbursements for transportation and lodging are available only if the patient is using an approved network transplant facility.

• The plan pays for transportation of the patient and one companion, who is traveling on the same day(s) to and from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.

• The plan pays reasonable and necessary expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 per day for all family members combined. If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered and lodging will be reimbursed up to the $100 per diem rate for all family members combined.

• Travel and lodging expense reimbursement is available only if the transplant recipient resides more than 50 miles from the approved network transplant facility.

There is a combined overall lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by the transplant recipient and companion(s) and reimbursed under the plan in connection with all transplant procedures.

Donor charges are covered only if the recipient of the organ/tissue transplant is covered under this plan.

UnitedHealthcare will assist the patient and family with travel and lodging arrangements.
Orthotics

<table>
<thead>
<tr>
<th>Network</th>
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<tr>
<td>Out-of-Network</td>
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</tr>
</tbody>
</table>

The plan can help pay covered charges for the following:

- Braces for treatment to an injured body part.
- Braces to treat curvature of the spine.
- Allowed items under Medical Supplies and Equipment as durable medical equipment.

All other orthotic appliances and devices are excluded from coverage such as foot orthotics or orthotic braces available over-the-counter.

Podiatry Services

<table>
<thead>
<tr>
<th>Network</th>
<th>90% of contracted fees after deductible for office visits or treatment in an outpatient facility.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Network</td>
<td>80% of allowable charges after deductible for office visits or treatment in an outpatient facility.</td>
</tr>
</tbody>
</table>

The plan can help pay covered charges for podiatry services that are required as the result of a severe systemic disease.

The plan does not cover routine foot care, including care for corns or calluses, nail trimming, cleaning and soaking the foot, and treatment of flat feet. For details, see Expenses That Aren’t Covered Under the Plan in this section.

Prenatal Care

<table>
<thead>
<tr>
<th>Network</th>
<th>100% of contracted fees for routine prenatal care that qualifies as preventive care. 90% of contracted fees, after deductible, for prenatal care that does not qualify as preventive care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Network</td>
<td>100% of allowable charges for routine prenatal care that qualifies as preventive care. 80% of allowable charges, after deductible, for prenatal care that does not qualify as preventive care.</td>
</tr>
</tbody>
</table>

Expectant mothers can participate in a special education program called the Maternity Support Program managed by the Chevron Nurse Advisor Team. To enroll in or learn more about this voluntary program, call UnitedHealthcare at 1-800-654-0079 and choose “Speak with a Nurse”. UHC’s Maternity Support Program is provided at no charge to you and gives you the following:

- Telephone access to registered nurses throughout your pregnancy.
- Telephone consultation by a registered nurse to ensure that your pregnancy is going well.
- A packet of valuable information related to pregnancy.
Preventive Care

<table>
<thead>
<tr>
<th>Network</th>
<th>100% of contracted fees, no deductible.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Network</td>
<td>100% of allowable charges, no deductible.</td>
</tr>
</tbody>
</table>

Preventive care services as required by the Patient Protection and Affordable Care Act and in accordance with guidelines based on recommendations from nationally recognized organizations, such as the U.S. Preventive Services Task Force. For a list of preventive care services you can contact UnitedHealthcare at 1-800-654-0079 or access online at [www.uhcpreventivecare.com](http://www.uhcpreventivecare.com).

Private-Duty Nursing

<table>
<thead>
<tr>
<th>Network</th>
<th>90% of contracted fees after deductible, up to 1,000 hours or 120 days per calendar year (whichever comes first).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Network</td>
<td>80% of allowable charges after deductible, up to 1,000 hours or 120 days per calendar year (whichever comes first).</td>
</tr>
</tbody>
</table>

If your doctor prescribes private-duty nursing care outside the hospital, be sure to contact UnitedHealthcare to receive full plan benefits. You must notify UHC’s Personal Health Support at least five business days before you or a dependent begins receiving private-duty nursing services; otherwise, the benefit is reduced to 60 percent.

The plan will not pay benefits for private-duty nursing in a hospital or skilled nursing facility because it is not considered medically necessary since hospitals provide adequate nursing services. Custodial care isn’t covered by the plan, even if it’s prescribed by a doctor and provided by a nurse.

Rehabilitation Therapy (inpatient)

<table>
<thead>
<tr>
<th>Network</th>
<th>90% of contracted fees after deductible, up to a maximum of 120 visits per calendar year (combined network and out-of-network visits).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Network</td>
<td>80% of allowable charges after deductible, up to a maximum of 120 visits per calendar year (combined network and out-of-network visits).</td>
</tr>
</tbody>
</table>

Benefits are available for services and supplies received during an inpatient stay in an inpatient rehabilitation facility, including room and board in a semiprivate room (a room with two or more beds). In general, the intent is to provide benefits for members who are convalescing from an injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services that are less than those available in a general acute hospital but greater than those available in the home setting. The patient is expected to improve to a predictable level of recovery. Benefits are available when rehabilitation services are needed on a daily basis and, accordingly, benefits are not available when these services are required intermittently (such as physical therapy three times a week). However, coverage for therapies on intermittent frequencies may be covered under other plan benefits.
Benefits are not available for custodial, domiciliary or maintenance care (including administration of enteral feeds). This care is not covered, even if it is ordered by a doctor, if it is for the primary purpose of meeting personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Remember to notify UnitedHealthcare’s Personal Health Support at least three business days before therapy begins.

**Rehabilitation Therapy (outpatient)**

<table>
<thead>
<tr>
<th>Network</th>
<th>90% of contracted fees after deductible, up to a maximum of 30 visits per calendar year (combined network and out-of-network visits).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Network</td>
<td>80% of allowable charges after deductible, up to a maximum of 30 visits per calendar year (combined network and out-of-network visits).</td>
</tr>
</tbody>
</table>

The plan pays benefits for short-term outpatient rehabilitation services for pulmonary rehabilitation therapy and cardiac rehabilitation therapy. With any combination of network and out-of-network benefits, outpatient rehabilitation therapy is limited to 30 visits of pulmonary rehabilitation therapy per calendar year and 30 visits of cardiac rehabilitation therapy per calendar year. These limits, however, will not be combined with other therapy limits. The rehabilitation services must be performed by a licensed therapy provider under the direction of a doctor.

**Second and Third Physician Opinions**

<table>
<thead>
<tr>
<th>Network</th>
<th>100% of contracted fees after deductible.</th>
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</thead>
<tbody>
<tr>
<td>Out-of-Network</td>
<td>80% of allowable charges after deductible</td>
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</tbody>
</table>

The second or third opinion must be obtained from a board-certified surgeon who is not the surgeon originally scheduled to perform the surgery. The plan can help pay covered charges for the following:

- Charges for laboratory and x-ray examinations.
- Charges for the diagnostic procedures associated with the consultation.

**Skilled Nursing Facility Care**

<table>
<thead>
<tr>
<th>Network</th>
<th>90% of contracted fees after deductible, up to 120 calendar days (combined network and out-of-network).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Network</td>
<td>80% of allowable charges after deductible, up to 120 calendar days (combined network and out-of-network).</td>
</tr>
</tbody>
</table>

After you pay the deductible, the plan pays a percentage of covered charges for care in an approved skilled nursing facility for up to 120 days each calendar year (combined network and out-of-network).
If a doctor prescribes the care in a skilled nursing facility and you or your enrolled dependent would otherwise be cared for in a hospital (and the care is not custodial), the plan pays covered charges for the following services and supplies:

- Semiprivate room and board.
- Skilled nursing care.
- Medical supplies and equipment.
- Prescribed drugs and biologicals.
- Other services ordinarily provided by the facility.

The confinement must be the result of the same or a related condition as the hospital confinement and must be supervised and certified in writing by a doctor.

You or your doctor should call UnitedHealthcare to make sure the facility you select qualifies as a skilled nursing facility under the terms of the plan. The plan doesn’t pay any benefits for custodial care, even if it’s provided by an approved skilled nursing facility. If your stay in the facility extends into the next calendar year, an additional 120 days of benefits are available without a second hospital confinement.

You should notify UHC’s Personal Health Support at least five business days before receiving services.

**Surgery**

Generally, except where noted:

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<thead>
<tr>
<th>Network</th>
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<tbody>
<tr>
<td>Out-of-Network</td>
<td>80% of allowable charges after deductible.</td>
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</table>

- If you need to be hospitalized for an operation, you or your doctor must notify UnitedHealthcare in order to receive the full benefits provided by the plan. If it is not an emergency, you should call three business days before surgery is performed. If it is an emergency, you should call within two business days after emergency surgery is performed.
- Surgical testing for inpatient or outpatient surgery is covered at the 90 percent of contracted fees (network) or 80 percent of allowable charges (out-of-network) after the deductible.
The HDHP can help pay covered charges for:

- Surgeons’ services (including charges for any medically necessary assistant surgeon or standby surgeon).

- The maximum allowable covered medical expense for an assistant surgeon is 16 percent of the contracted fees (network) or 16 percent of the allowable charges (out-of-network) for the surgical procedure performed. The plan then reimburses that amount at 90 percent of contracted fees (network) or 80 percent of allowable charges (out-of-network) after the deductible.

- Anesthesia supplies and the services of an anesthesiologist.

- Hospital operating and recovery rooms; services and supplies associated with the surgery.

- Ambulatory surgical center operating and recovery rooms; services and supplies associated with the surgery.

- Outpatient surgical procedures.

- Certain organ and tissue transplants, when ordered by a doctor.

- Certain reconstructive surgery.

- Second and third surgical opinions.

**Multiple Surgical Procedures**

After you pay the deductible, the plan pays 90 percent of contracted fees (network) for multiple surgical procedures.

If more than one surgical procedure is performed during any one operative session, reimbursement for out-of-network surgeons’ services will be based on the allowable amount, which is 100 percent of covered charges for the primary procedure and 50 percent of covered charges for each additional procedure.

For example, let’s say the primary procedure’s allowable charge is $100. Let’s also assume that the secondary procedure has an allowable charge of $100. The reimbursement for the secondary procedure will be based on $50 (50 percent of $100). If your deductible has been met and the coinsurance is 80 percent, the plan will pay $120 (80 percent of $150) and you will pay $80 ($200 – $120).
Reconstructive Surgery
After you pay the deductible, the plan covers reconstructive surgery under the following conditions:

- To improve the function of a body part when the malfunction is the direct result of a birth defect, sickness, surgery to treat a sickness or accidental injury, or an accidental injury.

- To remove scar tissue on the neck, face or head, if scar tissue is due to sickness or an accidental injury.

- Following a mastectomy, as well as reconstruction of the other breast to produce a symmetrical appearance. Coverage also is provided for prostheses and for treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Second and Third Surgical Opinions
Second and third surgical opinions are used to determine whether the surgery is medically necessary. After you pay the deductible, the plan pays 100 percent of contracted fees (network) or 100 percent of allowable charges (out-of-network). The second or third opinion must be obtained from a board-certified surgeon who is not the surgeon originally scheduled to perform the surgery. Covered charges include:

- Charges for the surgical consultation.

- Charges for laboratory and x-ray examinations.

- Charges for the diagnostic procedures associated with the consultation.

Therapy Treatments
After you pay the deductible, the plan can help pay covered charges for therapy treatments prescribed by a doctor and provided by a licensed physical, occupational, speech, orthoptic or other therapist. The plan pays up to the maximum number of visits per calendar year for each type of therapy.

Physical, Occupational, and Speech Therapy

<table>
<thead>
<tr>
<th>Network</th>
<th>90% of contracted fees after deductible for office visits or treatment in an outpatient facility; up to a maximum of 90 visits per calendar year (combined network and out-of-network visits for physical, occupational and speech therapies).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Network</td>
<td>80% of allowable charges after deductible for office visits or treatment in an outpatient facility; up to a maximum of 90 visits per calendar year (combined network and out-of-network visits for physical, occupational and speech therapies).</td>
</tr>
</tbody>
</table>

Physical Therapy
Outpatient services for physical therapy are covered. The plan pays benefits only for therapy services given by a licensed or certified provider acting within the scope of that license or certification. Inpatient services for physical therapy are covered as inpatient hospital benefits. For additional benefits, see Rehabilitation Therapy (inpatient) and Rehabilitation Therapy (outpatient) in this section.
**Occupational Therapy**
Outpatient services for occupational therapy are covered. The plan pays benefits only for therapy services given by a licensed or certified provider acting within the scope of that license or certification. Inpatient services for occupational therapy are covered as inpatient hospital benefits. For additional benefits, see Rehabilitation Therapy (inpatient) and Rehabilitation Therapy (outpatient) in this section.

**Speech Therapy**
The plan pays benefits for speech therapy only when the speech impediment or speech dysfunction results from injury, stroke, cancer, sickness or a congenital anomaly. For example, the services of a licensed speech therapist are covered to restore speech lost or impaired due to surgery, radiation therapy or other treatment that affects the vocal chords; cerebral thrombosis; brain damage due to accidental injury or organic brain lesion (aphasia); or accidental injury.

In addition, benefits are paid for services of a licensed speech therapist for treatment given to a child under age 26 whose speech is impaired due to one of the following conditions:

- Autism spectrum disorders.
- Pervasive developmental disorders.
- Development delay or cerebral palsy.
- Hearing impairment.
- Major congenital anomalies that affect speech, such as, but not limited to, cleft lip and cleft palate.

**Orthoptic Therapy**

<table>
<thead>
<tr>
<th>Network</th>
<th>90% of contracted fees after deductible for office visits or treatment in an outpatient facility; up to a maximum of 30 visits per calendar year.</th>
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</tr>
</tbody>
</table>

**Orthoptic Therapy**
Outpatient services for orthoptic therapy are covered. The plan pays benefits only for orthoptic therapy services given by a licensed or certified provider acting within the scope of that license or certification. Orthoptic therapy is an individualized treatment program prescribed to eliminate or improve conditions such as amblyopia (lazy eye), strabismus (crossed eyes), focusing, eyeteaming and tracking disorders. Inpatient services for orthoptic therapy are covered as inpatient hospital benefits. For additional benefits, see Rehabilitation Therapy (inpatient) and Rehabilitation Therapy (outpatient) in this section.
Expenses That Aren’t Covered Under the Plan

The HDHP does not cover the following:

- Services or supplies provided during times you or your covered dependents were not covered under the plan.

- Services and supplies provided before you meet the HDHP’s deductible except for certain preventive care as specified by the ACA.

- Services and supplies that do not meet the definition of a covered charge.

- Charges in excess of the plan’s allowable charges.

- Charges for services, supplies, procedures and treatments that are not medically necessary.

- With respect to a network provider, charges in excess of the contracted rate.

- Services provided by foreign and sign language interpreters.

- Diagnostic services, supplies, tests, or procedures (other than mammography) furnished by a Hospital or other diagnostic facility which are self-directed or ordered by a Provider affiliated with such diagnostic facility who is not actively involved in your medical care.

- Confinement, treatment, services or supplies given for, or related to, any of the following:
  - Abdominoplasty.
  - Liposuction.
  - Speech therapy for fluency disorders.
  - Chelation therapy, except to treat heavy metal poisoning.
  - Tobacco dependency, except as specifically covered by the Mental Health and Substance Abuse Plan or the Prescription Drug Program.
  - Massage therapy, including, but not limited to, Rolfing.
  - Membership costs for health clubs, purchase of home whirlpools, spas and saunas for any reason.
  - Tine test for tuberculosis.
  - Herbal medicine, holistic or homeopathic care, including, but not limited to, drugs, aromatherapy and ecological or environmental medicine.
  - Personal convenience or comfort items or general household goods, including, but not limited to, the purchase or rental of radios, TVs, telephones, first-aid kits, exercise equipment, air conditioners, humidifiers, food liquefiers, newspapers or bedside service tables, or the cost of meals for guests.

- Charges for broken appointments or for completing or processing claim forms, for telephone conversations for consultations or for Internet consultations.
• Cosmetic or reconstructive surgery or procedures, except reconstructive surgery that’s specifically covered under the plan.

• Physical appearance:
  — Cosmetic surgery or treatment (surgery or treatment primarily to change appearances), whether or not for psychological or emotional reasons, including confinement, treatment, services or supplies, including:
    – Cosmetic procedures.
    – Pharmacological regimens.
    – Nutritional procedures or treatments (including gastric bypass).
    – Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
    – Skin abrasion procedures performed as a treatment for acne.
  — Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure. Note that replacement of an existing breast implant is considered reconstructive rather than cosmetic if the initial breast implant followed a mastectomy.
  — Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility and diversion or general motivation.
  — Weight reduction or control, whether or not they are under medical supervision (such as Jenny Craig™ and Weight Watchers™). Membership costs for weight-loss clinics and similar programs and special foods, food supplements, liquid diets, diet plans or other related products.
  — Wigs, toupees, hair transplants, hair weaving, or any drug used in connection with baldness, regardless of the reason for the hair loss, including congenital alopecia (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury).
  — Medical and surgical treatment of excessive sweating (hyperhidrosis).
  — Obesity surgery (unless accompanied by a diagnosis of morbid obesity).

• Treatment of benign gynecomastia (abnormal breast enlargement in males).

• Medical and surgical treatment for snoring and appliances that prevent snoring (except when provided as a part of treatment for documented obstructive sleep apnea).

• Custodial care.

• Eye refractions (vision screenings), eyeglasses, contact lenses and other vision-related supplies, services and procedures, except as specifically covered by the vision program or unless required by an accidental injury. Surgical procedures to correct refraction errors of the eyes (for example, LASIK or PRK), including any confinement, services or supplies given in connection with, or related to, the surgery, are excluded (see the Basic Vision section).

• Hearing aids and cochlear implants (except as specifically covered under the High Deductible Health Plan) and dental prosthetic appliances, other than when required in connection with temporomandibular joint dysfunction (TMJ), or the fitting of any of these supplies, unless required by an accidental injury (see Dental Care under What the Plan Pays in this section).
• Services provided by any person who is a member of your immediate family or who resides in your home.

• Charges related to surrogate parents.

• Charges incurred by a sperm or egg donor.

• Elective amniocentesis or other tests performed solely to learn the sex of the unborn child.

• Home delivery of a newborn child.

• Treatment in a U.S. government or agency hospital. However, the reasonable cost incurred by the U.S. or one of its agencies for inpatient medical care and treatment given by a hospital of the uniformed services may be covered under the plan. The cost of this inpatient medical care and treatment will be covered if the charges for the care and treatment are otherwise covered under this plan and the care and treatment were provided to one of the following:
  — A person retired from the uniformed services.
  — A family member of a person who is retired from the uniformed services.
  — A family member of a person who is active in the uniformed services.
  — A family member of a deceased member of the uniformed services.

• Expenses that you, yourself, are not legally required to pay. However, the reasonable cost incurred by the U.S. for medical care and treatment given to a veteran by the U.S. or one of its agencies may be covered under these plans. The cost of the care and treatment will be covered if:
  — The veteran does not have a service-related disability.
  — Charges for the care and treatment are otherwise covered under the plan.

• Treatment or services provided by a government facility or doctor, or payable under a government plan or program, except as required by law.

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

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

• Charges for services that aren't considered acceptable and appropriate by the general medical community.

• Services given by a pastoral counselor (except as provided under Hospice Care in What the Plan Pays in this section).
• Private-duty nursing services while confined in a hospital or other facility.

• Services or supplies in connection with organ or tissue transplants, except as specifically provided by the plan (see Organ and Tissue Transplants in What the Plan Pays in this section).

• Education, training, and bed and board in an institution that is primarily a school, or other institution for training or a place of rest, or a domicile for the aged.

• Auxiliary items normally available without a prescription, even though they’re recommended by a doctor (including items such as posture chairs, hot tubs, exercise bicycles and other exercise equipment).

• Routine physical exams required for insurance, licensing, employment, school, camp or other nonpreventive purposes.

• Any tests required for a marriage license.

• Equipment for environmental control or general household use (such as air conditioners and food liquefiers).

• Immunizations for travel outside the U.S. or for occupational requirements.

• Payments for which you’re reimbursed or are eligible to receive reimbursement as a result of any award or settlement from a third party for medical expenses resulting from an act or failure to act of the third party — including reimbursements under no-fault automobile insurance — unless you or your dependent agrees to reimburse the plan when damages are recovered from the third party.

• Examinations or treatment ordered by a court in connection with legal proceedings, unless these examinations or this treatment otherwise qualifies as covered charges.

• Products purchased for nutrition purposes, including, but not limited to:
  — Megavitamin and nutrition-based therapy.
  — Nutritional counseling for either individuals or groups, including weight-loss programs, health clubs and spa programs, are excluded except in cases where the nutritional counseling is medically necessary, related to a condition that is covered by the plan, and performed by a registered dietician in individual sessions (benefits are limited to three sessions per lifetime for each medical condition). Some examples of medically necessary nutritional counseling are when the patient is diagnosed with diabetes mellitus, coronary artery disease, congestive heart failure, severe obstructive airway disease, gout, renal failure, phenylketonuria, and hyperlipidemias.
  — Enteral feedings and other nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low-fat, cholesterol), oral vitamins or oral minerals (however, these items may be covered if the formula or supplement is the sole source of nutrition or treats a specific inborn error of metabolism, is prescribed and is not available over the counter).
• Medical supplies and appliances:
  — Devices used specifically as safety items or to affect performance in sports-related activities.
  — Prescribed or non-prescribed medical supplies and disposable supplies, including:
  — Elastic stockings.
  — Ace bandages.
  — Gauze and dressings.
  — Syringes and diabetic test strips (covered under Prescription Drug Program).
  — Orthotic appliances that straighten or reshape a body part (including some types of braces).
  — Tubings and masks, except when used with covered durable medical equipment.
  — Foot care (except when needed for severe systemic disease):
    — Routine foot care (including the cutting or removal of corns and calluses), nail trimming, cutting or debriding.
    — Hygienic and preventive maintenance foot care, including cleaning and soaking the feet.
    — Applying skin creams in order to maintain skin tone.
    — Other services that are performed when there is not a localized illness, injury or symptom involving the foot.
    — Treatment of flat feet.
    — Treatment of subluxation of the foot.
    — Shoe orthotics.
  — Treatment for mental health or substance abuse problems (covered under the Mental Health/Substance Abuse Plan).

• Charges for preventive services that are not medically necessary and are not considered covered preventive care under the plan.

• Charges you’re not required to pay.

• Dental care, except care that’s specifically covered under the plan.

• Any drugs, unless provided while confined in a hospital or unless they are injectable drugs that are routinely or customarily administered by a doctor or registered nurse (R.N.) in the provider’s office.

• Any type of therapy, service or supply, including, but not limited to, spinal manipulations by a chiropractor or other doctor, for the treatment of a condition that ceases to be therapeutic treatment, as determined by UnitedHealthcare and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

• Non-rehabilitative educational care.

• Treatment or services that aren’t prescribed as necessary by a doctor.

• Charges for which a claim for benefits isn’t filed within six months (by June 30) following the year in which the covered charge is incurred.
• Transportation, other than the transportation services specifically provided by the plan.

• Sensitivity training or educational training therapy or treatment for an education requirement.

• Services provided while the recipient is covered under another health care plan to which Chevron contributes or has made contributions on your behalf.

• For services, supplies, or treatments (and related confinements) that the Claims Administrator determines to be experimental services or investigational services or unproven

• Hospital charges for a private room in excess of the hospital’s regular daily rate for semiprivate room accommodations.

• Services of a doctor who is in attendance but who is not providing face-to-face care or who is a standby surgeon to a surgical procedure (except as specifically covered under the High Deductible Health Plan).

• Services of a doctor’s assistant.

• Skilled nursing facility charges for a private room in excess of the skilled nursing facility’s regular daily rate for semiprivate room accommodations.

• Services and supplies in connection with an occupational injury or sickness. An occupational injury or sickness is an injury or sickness that is covered under a workers’ compensation act or similar law. For persons for whom coverage under a workers’ compensation act or similar law is optional because they could elect it or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the workers’ compensation act or similar law, had that coverage been elected.
Health Care Review

The plan includes Health Care Review procedures to help you get appropriate medical care in a cost-effective setting.

You or your provider must contact Personal Health Support at 1-800-654-0079 before you can qualify for full plan benefits for the following kinds of care:

- Inpatient hospital stay.
- Inpatient childbirth (if stay exceeds federally mandated guidelines).
- Reconstructive surgery and procedures.
- Organ and tissue transplants (the facility needs to be approved by UnitedHealthcare).
- Inpatient rehabilitation.
- Skilled nursing facility care.
- Private-duty nursing.
- Home health care.
- Home infusion therapy.
- Hospice care (the hospice agency needs to be approved by UnitedHealthcare).
- Durable medical equipment (if purchase or cumulative rental cost exceeds $1,000).
- Accident dental services.
- Alternative treatments.
- Gender Identity Disorder

It’s your responsibility to make sure Personal Health Support is called if you or a family member needs hospitalization or any of the other treatments described in this Health Care Review section. It is not necessary to call Personal Health Support if you or a family member needs outpatient surgery.

After you call Personal Health Support, a health care professional will discuss the proposed treatment with your doctor and advise both you and your doctor of UHC’s decision regarding coverage. In some cases, Personal Health Support may suggest that your doctor consider an alternative course of treatment.

When you notify UHC, it does not imply that the plan will pay full benefits or any benefits at all for a particular claim. Even though a provider prescribes treatments or services, UHC determines if the treatments or services are covered by the plan and are medically necessary.
If treatment is not considered medically necessary, the plan will not pay benefits. If you don’t call within the required time period, benefits may be reduced to 60 percent of covered charges after the deductible, or may not be payable at all.

For more information about Health Care Review appeals, see Appealing Health Care Review Decisions in this section.

Inpatient Hospital Stay
Call Personal Health Support three or more business days before you’re admitted, or within two business days after an emergency hospital admission.

- **Before you’re hospitalized**: Personal Health Support reviews your case with your doctor and advises on the anticipated number of days of hospitalization that may be needed.

- **While you’re hospitalized**: Personal Health Support checks with your doctor to see how your treatment is progressing, and may arrange for additional care, such as visiting nurse services at home, or care in a rehabilitation center or skilled nursing facility.

To qualify for full plan benefits, you must notify Personal Health Support. If you don’t contact Personal Health Support before you’re hospitalized, the plan will pay only 60 percent of covered hospital room and board charges after you pay your deductible. If Personal Health Support determines that hospitalization isn’t medically necessary, no plan benefits will be paid for your hospital stay. In this case, you or your provider can appeal the decision.

Even if you and your doctor follow the plan’s Health Care Review procedures, the plan won’t cover any charges for services that aren’t medically necessary, as determined by UHC. If you have a question about covered charges, contact UHC at 1-800-654-0079.

Inpatient Childbirth (if stay exceeds federally mandated guidelines)
The following applies for both network and out-of-network childbirth services. No approval or preauthorization is needed from UHC for maternity admissions. In accordance with the Newborns’ and Mothers’ Health Protection Act of 1996, the plan may not restrict benefits for a mother’s or newborn child’s hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, the law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).

You must call UHC for a length of stay in excess of these periods. If you don’t notify Personal Health Support about an extended stay (prior to the extended stay), benefits for the additional days are reduced to 60 percent of covered charges, after the deductible.
Reconstructive Surgery and Procedures
The plan can help pay for reconstructive surgery required to repair a birth defect or damage due to an accidental injury or disfiguring disease. To receive benefits for reconstructive surgery, you must notify Personal Health Support.

Consistent with the Women’s Health and Cancer Rights Act of 1998, if you have a mastectomy and elect reconstructive surgery in connection with the mastectomy, coverage is provided for all of the following:

- Reconstruction of the breast on which the mastectomy is performed.
- Reconstruction and surgery of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment remedies for physical complications during all stages of the mastectomy, including lymphedemas.

If you don’t contact Personal Health Support at least three business days before you receive reconstructive surgery, benefits may be reduced to 60 percent of covered charges after you satisfy the deductible.

Organ and Tissue Transplants
Personal Health Support notification is required for all organ and tissue transplant services. You need to contact Personal Health Support as soon as transplantation is a possibility. If you don’t contact Personal Health Support in advance, benefits may be reduced to 60 percent of covered charges after you satisfy the deductible. For the transplant expense to be covered by the plan, all of the following must apply:

- The transplant must be medically necessary.
- The transplant must be performed by approved doctors.

The transplant must be performed at an approved facility or at a Center of Excellence for liver, heart, heart-lung, lung, kidney, kidney-pancreas, liver-small bowel, pancreas, small bowel or bone marrow transplants, including autologous bone marrow transplants, peripheral stem-cell replacement and similar procedures.

The plan has specific guidelines regarding benefits for transplant services. For example, the transplant must be done at a facility approved or designated by Personal Health Support. For information about these guidelines, contact Personal Health Support at the telephone number on your ID card.

Cornea transplants are not covered by UHC under the transplant program. Instead, they are covered as any other surgery.

Transportation and Lodging
Personal Health Support will assist the patient and family with travel and lodging arrangements.

You or your network doctor must notify Personal Health Support before the time a pre-transplantation evaluation is performed at a transplant center. If you do not notify Personal Health Support, and if the services are not performed at a facility approved by UHC, benefits may be reduced to 60 percent of covered charges after you satisfy the deductible.
Rehabilitation (inpatient)
If your doctor prescribes inpatient rehabilitation, you must notify Personal Health Support at least three business days before this care starts. If you don’t make the call, benefits for inpatient rehabilitation may be reduced to 60 percent of covered charges after you satisfy the deductible.

Skilled Nursing Facility Care
If your doctor prescribes care in a skilled nursing facility, you must notify Personal Health Support at least five business days in advance. If you don’t make the call, benefits for skilled nursing facility care may be reduced to 60 percent of covered charges after you satisfy the deductible. Custodial care isn’t covered by the plan, even if it’s prescribed by a doctor and provided by a nurse.

Private-Duty Nursing
If your doctor prescribes private-duty nursing care outside the hospital, you must notify Personal Health Support at least five business days before this care starts. If you don’t make the call, benefits for private-duty nursing may be reduced to 60 percent of covered charges after you satisfy the deductible. Custodial care isn’t covered by the plan, even if it’s prescribed by a doctor and provided by a nurse.

Home Health Care
If your doctor recommends home health care services, you must call Personal Health Support at least five business days before services begin. If you don’t call Personal Health Support within this time period your benefits may be reduced to 60 percent of covered charges after you satisfy the deductible.

Personal Health Support decides if skilled home health care is required by reviewing both the skilled nature of the service and the need for doctor-directed medical management. A service is not determined to be skilled simply because there is not an available caregiver. Personal Health Support also must approve the home health care agency before benefits are payable.

Home Infusion Therapy
If your doctor recommends home infusion therapy for you or your dependent, you must notify Personal Health Support. If you fail to make the call or if you call less than five business days before receiving services, any subsequently approved benefits may be reduced to 60 percent of covered charges after you satisfy the deductible.

Hospice Care
If your doctor recommends hospice care, you must call Personal Health Support before services begin. If you don’t call Personal Health Support in advance, your benefits may be reduced to 60 percent of covered charges after you satisfy the deductible. Personal Health Support also must approve the hospice agency or facility before benefits are payable.

Durable Medical Equipment
(If purchase or cumulative rental cost exceeds $1,000)
If your doctor prescribes the use of durable medical equipment, and the cost of purchase or cumulative rental of any single item is more than $1,000, you must seek approval from Personal Health Support. Personal Health Support will decide if the equipment should be purchased or rented. To receive network benefits, you must purchase or rent the durable medical equipment from the vendor that Personal Health Support identifies. When the purchase or rental cost exceeds $1,000 and you don’t call Personal Health Support before obtaining the equipment, no benefits are payable. Certain durable medical equipment requires periodic recertification.
**Accident Dental Services**

After an accident, the plan will pay benefits for dental services when *all* of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a doctor of dental surgery (D.D.S.) or a doctor of medical dentistry (D.M.D.).
- Benefits are available only for treatment of a sound, natural tooth. The doctor or dentist must certify that the injured tooth was one of the following:
  - A virgin or unrestored tooth.
  - A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss and no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must meet both of the following criteria:

- Started within three months of the accident.
- Completed within 12 months of the accident.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an accident. Benefits are not available for repairs to teeth that are injured as a result of such activities.

You don’t need to notify Personal Health Support before emergency treatment. However, if treatment requires inpatient hospitalization, you do need to call Personal Health Support within two business days after being admitted; otherwise, benefits may be reduced to 60 percent of covered charges after you satisfy the deductible.

For follow-up (nonemergency) treatment, please remember to notify Personal Health Support as soon as possible, but no later than three business days before follow-up treatment occurs. When you provide notification, Personal Health Support can verify that the service is medically necessary.

**Alternative Treatments**

In very limited cases, the plan may pay for *alternative medical treatment*. Reasonable charges for services or supplies that aren’t otherwise covered charges can be considered if all of the following apply:

- They are determined by UHC’s Personal Health Support to be a medically reasonable alternative, having a cost equal to or lower than the current or projected course of treatment.
- They don’t involve a permanent improvement to the member’s or patient’s residence.
- They are prescribed for the treatment of the patient’s disease or condition as an aid to recovery and are not primarily related to non-rehabilitative education or custodial care.

Alternative treatment determinations are made by UHC’s Personal Health Support and must be approved in advance.
Appealing Health Care Review Decisions
If you contact UHC’s Personal Health Support for Health Care Review, and Personal Health Support
determines that a treatment or test isn’t medically necessary or isn’t covered by the plan for other
reasons, you and your provider can appeal this decision.

To understand how appeals work, see the Initial Claim Review and Decision section. Depending on the
type of claim, you have a specific time frame to request an appeal from Personal Health Support,
and Personal Health Support has a specific time frame to respond to your appeal.

Anytime you notify Personal Health Support in advance for authorization before you receive treatment, it
is considered a preservice claim.

If your appeal results in another denial, you and your provider can go ahead with the proposed treatment,
but your claim for plan benefits will be denied because the treatment wasn’t approved in advance. In this
case, you can appeal the denial of your claim.
Medical Claims and Appeals

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

How to File a Medical Claim

If you go to a network provider for care, your provider files the claim for you; otherwise, you have to file a claim as explained here.

If you go to an out-of-network provider for care, you should file a medical claim as soon as you incur a covered charge, even if you haven’t yet paid your deductible. Claim forms are available by clicking on Forms at www.myuhc.com or by calling UnitedHealthcare at 1-800-654-0079. Claim forms also are available from the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.) or on the Benefits Connection website at hr2.chevron.com.

When you receive services from an out-of-network provider, you are responsible for requesting payment from UnitedHealthcare. You must file the claim in a format that contains the following information:

- Your name and address.
- Patient’s name and date of birth.
- Subscriber number stated on your ID card.
- Name, address, telephone number and tax identification number of the provider of the service(s).
- Diagnosis from the doctor.
- Itemized bill from your provider that includes the standard insurance billing codes typically referred to as current procedural terminology (CPT) codes.
- Date the injury or sickness began.
- Statement indicating whether you are or you are not enrolled in coverage under any other health insurance plan or program. If you are enrolled in other coverage, you must include the name of the other claims administrator(s).

The address of the claims administrator is:

UnitedHealthcare
Chevron Group No. 247848
P.O. Box 30555
Salt Lake City, UT 84130-0555
You must file a claim for payment of plan benefits no later than six months (by June 30) following the calendar year in which the service was provided. If you don’t file a proper claim with the claims administrator within this time frame, benefits for that health service will be denied. This time limit does not apply if you are legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

If you provide written authorization to allow direct payment to a provider, all or a portion of any eligible covered charges due to a provider may be paid directly to the provider instead of being paid to you. UnitedHealthcare will not reimburse third parties who have purchased or been assigned benefits by doctors or other providers.

If your claim is denied, or if UnitedHealthcare needs more information before it can approve your claim, you’ll be notified in writing. When a claim is denied, you can appeal the denial, as described further below.

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 book.

**Note:** For information on how to file a prescription drug claim or a basic vision claim, please see the High Deductible Health Plan – Prescription Drug Coverage and the High Deductible Health Plan – Basic Vision Coverage sections.

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

**Types of Claims**
There are generally three types of claims with respect to an ERISA group health plan:

- **Urgent care claim:** Any claim for medical care or treatment with respect to which the application of the time periods for making nonurgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or which, in the opinion of your doctor, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

- **Preservice claim:** Any claim for a benefit with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on your obtaining approval by the Health Care Review Program before you receive such medical services.

- **Postservice claim:** Any claim that is not a preservice claim — that is, does not require Health Care Review Program approval — and that is filed for payment of benefits after medical care has been received.

Another type of claim is the concurrent care claim. For more information, see Concurrent Care Claims in this section.
Time Limits for Processing Claims
The claims administrator must follow certain time limits when processing claims for plan benefits:

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

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

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

<table>
<thead>
<tr>
<th>Time Limits for Processing Claims</th>
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<td><strong>This chart describes the time limits for processing different types of claims.</strong></td>
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<thead>
<tr>
<th>Time Limits</th>
<th>Urgent Care Health Claims</th>
<th>Types of Claims</th>
<th>Post-service Health Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan notice of failure to follow the proper claim procedures</strong></td>
<td>Not later than 24 hours after receiving the improper claim.</td>
<td>Not later than five days after receiving the improper claim.</td>
<td>N/A</td>
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<tr>
<td><strong>Your deadline to provide additional information required by the plan to decide your claim</strong></td>
<td>48 hours after receiving notice that additional information is required.</td>
<td>45 days after receiving notice that additional information is required.</td>
<td>45 days after receiving notice that additional information is required.</td>
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<tr>
<td><strong>Plan notice of initial claim decision</strong></td>
<td>1. Not later than 72 hours after receiving the initial claim, if it was proper and complete.</td>
<td>1. Not later than 15 days after receiving the initial claim, unless an extension, up to 15 days, is necessary due to matters beyond the control of the plan. The maximum time period is 30 days total. You will be notified within the initial 15 days if an extension is needed.</td>
<td>1. Not later than 30 days after receiving the initial claim, unless an extension, up to 15 days, is necessary due to matters beyond the control of the plan. The maximum time period is 45 days total. You will be notified within the initial 30 days if an extension is needed.</td>
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<td>2. Not later than 48 hours after receiving additional information or after the expiration of your 48-hour deadline to provide such information to complete the claim, whichever is earlier.</td>
<td>2. Not later than 15 days after receiving the initial claim, unless you need to provide additional information. You will be notified during the initial 15-day period and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving your additional information or after the expiration of your 45-day deadline to complete the claim, whichever is earlier.</td>
<td>2. Not later than 30 days after receiving the initial claim, unless you need to provide additional information. You will be notified during the initial 30-day period, and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving your additional information or after the expiration of your 45-day deadline to complete the claim, whichever is earlier.</td>
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</table>
Concurrent Care Claims
If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and your request to extend the treatment is an urgent care claim as defined under Types of Claims in this section, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The claims administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the time limits described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to pre-service or post-service time limits, whichever applies.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and there is a reduction or termination of the course of treatment (other than by plan amendment or termination) before the end of the period of time or number of treatments, the plan will notify you. This will be considered a denied claim. The notification will be sufficiently in advance of the reduction or termination to allow you to appeal the denial and receive a determination on appeal before the reduction or termination of the benefits. If you decide to appeal, you must follow the applicable appeals procedure described in If Your Claim Is Denied in the next section below.

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

Please note that for an urgent care claim, you will receive notice (whether adverse or not) in writing or electronically. This notice also may be given orally, with a written or electronic confirmation to follow within three days.

If your claim is approved, benefits will be paid to you unless the provider notifies the claims administrator that your signature is on file, assigning benefits directly to that provider. The claims administrator will not reimburse third parties who have purchased or have been assigned benefits by doctors or other providers. If your claim is denied, there is an additional procedure for appealing a denied decision. You should also be aware that the claims administrators have the right to request repayment if they overpay a claim for any reason.
If Your Claim Is Denied
If your claim is denied (in whole or in part), you will receive a written notice that includes the following:

- Information sufficient to identify the claim involved.
- 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 a civil lawsuit under Section 502(a) of ERISA following an adverse determination after completion of all levels of appeal-review required by the plan).
- Any additional information required by Department of Labor claim, appeal, and external review regulations.

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

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

**Before you officially appeal a denial of a claim**, you can call the claims administrator (see the Summary Chart under Administrative Information section) to see if a resolution is possible. For example, the claims administrator may need more information to process your claim. However, if no further information is needed or if you aren’t satisfied with the explanation of why the claim was denied, you can request, in writing, to have the claim reviewed. The claims administrator processes payments for claims, answers questions and reviews appeals according to the plan’s provisions.
How to File an Appeal
This section describes how to file an appeal with UHC and the time limits that apply to the different types of medical appeals.

<table>
<thead>
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<tr>
<td>Your deadline to file a first appeal</td>
<td>180 days after receiving the claim denial notice.</td>
<td>180 days after receiving the claim denial notice.</td>
<td>180 days after receiving the claim denial notice.</td>
</tr>
<tr>
<td>Plan notice of first appeal decision</td>
<td>Not later than 72 hours after receiving an appeal.</td>
<td>1. Not later than 15 days after receiving an appeal, if the plan allows two levels of appeal. 2. Not later than 30 days after receiving an appeal, if the plan allows one level of appeal.</td>
<td>1. Not later than 30 days after receiving an appeal, if the plan allows two levels of appeal. 2. Not later than 60 days after receiving an appeal, if the plan allows one level of appeal.</td>
</tr>
<tr>
<td>Your deadline to file a second appeal</td>
<td>N/A</td>
<td>90 days after receiving the first appeal denial notice.</td>
<td>90 days after receiving the first appeal denial notice.</td>
</tr>
<tr>
<td>Plan notice of second appeal decision</td>
<td>N/A</td>
<td>Not later than 15 days after receiving a second appeal.</td>
<td>Not later than 30 days after receiving a second appeal.</td>
</tr>
<tr>
<td>Your deadline to request an External Review</td>
<td>Four months after receiving the appeal denial notice.</td>
<td>Four months after receiving the second appeal denial notice.</td>
<td>Four months after receiving the second appeal denial notice.</td>
</tr>
<tr>
<td>IRO notice of External Review Decision</td>
<td>Not later than 72 hours after receiving the request.</td>
<td>Not later than 45 days after receiving the request for external review.</td>
<td>Not later than 45 days after receiving the request for external review.</td>
</tr>
</tbody>
</table>
First Appeal
After receiving the notice of denial, you or your authorized representative (this can be your provider, your beneficiary, your legal representative or another appropriately authorized individual) may ask for an appeal, which is a full and fair review of the initial claim decision, by writing to the claims administrator. You must make this request for an appeal in writing within the time limits noted in the chart above.

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

Your appeal should include all of the following:

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

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

For an urgent care claim, information may be provided by phone or fax.

Where to Send Your First Appeal
All of the claims administrators offer one appeal. In addition, UnitedHealthcare offers a second appeal, except that there is only one level of appeal for an urgent care claim. Send your appeal to the claims administrator:

UnitedHealthcare
Chevron Group No. 247848
P.O. Box 30432
Salt Lake City, UT 84130-0432

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

Time Limits and Procedures for Processing Your First Appeal
Upon receipt of your first appeal, the claims administrator will review the claim again and will make a decision based on all comments, documents, records and other information you’ve submitted, without regard to whether such information was submitted or considered in the initial benefit determination. This review will be completed within the time limits shown in the chart above, Time Limits for Processing Appeals.
As part of the appeals procedure, these steps are followed:

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

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

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

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

- If the claims administrator considers, relies upon, or generates any additional or new evidence during the appeal or if the claims administrator will base an impending denial upon any new or additional rationale, the claims administrator will provide such evidence or rationale as soon as possible in advance of the date the decision is due in order to give you a reasonable opportunity to respond prior to the decision being issued.

**Notice of Decision on First Appeal**

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

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

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

If your first appeal is denied based on an internal rule, guideline, protocol or other similar item, the notice will include a copy of the rule, guideline, protocol or item that was relied on to deny the claim. Alternatively, the notice will include a statement that an internal rule, guideline, protocol or similar item was relied on to deny your claim, and you can request a copy of it (the rule, guideline, protocol or other similar item) free of charge.
If your first appeal is denied based on medical necessity or experimental treatment or a similar exclusion or limit, the notice must include an explanation of the scientific or clinical judgment for the determination. It also must apply the terms of the plan to your medical circumstances. Alternatively, the notice will include a statement that such explanation will be provided to you free of charge upon request.

The notice will include any additional information required by Department of Labor claim, appeal, and external review regulations.

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

Note that there is only one level of internal appeal for an urgent care claim.

Second Appeal
The High Deductible Health Plan allows two levels of appeal (except for urgent care claims) for medical benefits. After receiving the notice of denial of your first appeal, you or your authorized representative (this can be your provider, your beneficiary, your legal representative or another appropriately authorized individual) may ask for a second appeal. You must make this request for a second appeal in writing within the time limits noted in the chart above, Time Limits for Processing Appeals, in the Time Limits for Processing Medical Benefit Appeals section. The second appeal should also include any additional information that wasn’t previously submitted with your first appeal, as well as an explanation supporting your position.

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

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

The second appeal will follow the same procedural steps as described for the first appeal. If the claims administrator considers, relies upon, or generates any additional or new evidence during the appeal or if the claims administrator will base an impending denial upon any new or additional rationale, the claims administrator will provide such evidence or rationale as soon as possible in advance of the date the decision is due in order to give you a reasonable opportunity to respond prior to the decision being issued.

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

If your second appeal is denied (in whole or in part), you will receive a written notice. The notice will contain information sufficient to identify the claim involved. 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 after all levels of required appeal/review have been exhausted. The notice will explain how to request an external review.
The notice will state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

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

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

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

Requesting an External Review
If your second appeal is denied, you may have the right to request an external review. An external review will be provided only when the claim denial involved medical judgment (for example, a denial based on the plan’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit or a determination that a treatment is experimental or investigational) or the matter is a rescission of coverage.

A de minimis (small) deviation from strict adherence to the internal claims and appeals procedure on the part of the relevant claims administrator or review panel that does not cause, or is not likely to cause, prejudice or harm to the claimant will not waive the requirement to exhaust the internal claims and review procedure before obtaining an external review or filing a lawsuit. The claims administrator shall provide an explanation of such deviation within 10 days of the request of the claimant. If a request for external review is denied on account of the failure to exhaust the internal claims and appeals process when a de minimis deviation is involved, the claimant shall have the right to pursue the internal process.

You or your authorized representative can request an external review in writing or verbally to the claims administrator by following the instructions in your denial notice or writing to the claims administrator at the address listed in the Administrative Information section. The claims administrator will provide an external review procedure through an accredited Independent Review Organization (IRO) after determining the following:

- You were covered under the plan at the time the services were provided.
- The claim denial is not a result of failure to meet the requirements for eligibility under the plan.
- You have exhausted the appeal process described above.

The IRO will conduct an external review of an adverse benefit determination and issue a final external review decision. The claims administrator will provide case information to the IRO and notify you of the name and contact information for the IRO reviewing your request for external review. The IRO will communicate their external review decision to you and the claims administrator. If the IRO determines that your explanation and additional information support the payment of your claim, the claims administrator will provide the

administrator will immediately provide coverage or payment of the claim. If your external review is denied, you will receive a written notice from the IRO.

**Expedited External Review**
You may request an expedited external review if any of the following apply:

- Your urgent care appeal is denied.
- The denial of your claim or appeal involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function.
- You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or if the final internal decision on review concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

To request an expedited external review, contact UnitedHealthcare:

Phone: 1-800-654-0079  
Fax: 1-813-818-3637  
Email: Plan_Sponsor_Appeal_Services@uhc.com  
Mail: UnitedHealthcare  
Attn: Central Escalation Unit/Appeals | 601 Brooker Creek Rd. | Oldsmar, FL 34677

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

Coordination of benefits is a feature used to determine how much the High Deductible Health Plan pays when you or one of your dependents is covered by more than one group medical plan. This feature is designed to prevent overpayment of benefits. This section does not apply to the basic vision coverage provided under the Vision Program.

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

The primary payer pays the benefits provided by its plan features. The secondary payer then pays any excess amounts required to bring the total benefits paid up to the levels payable under its plan. The sum of the benefits paid from each plan will not exceed the actual expense incurred. If the Chevron health plan is the secondary payer, the combined benefit from both plans won’t be more than the Chevron plan’s limit for the covered charges (except for the Chevron Dental Plan and the Prescription Drug Program).

If You or a Dependent Is Covered by More Than One Plan
A plan other than your High Deductible Health Plan will be the primary payer if any of the following conditions applies to the other plan:

- It doesn’t have a coordination of benefits rule.
- It covers the individual as an eligible employee or retiree (while your High Deductible Health Plan covers the individual as a dependent).
- It covers the individual as an employee (while your High Deductible Health Plan covers the individual as an eligible retiree).
- It has covered the individual longer than your High Deductible Health Plan (if the other conditions in this list don’t apply).
- It’s the Chevron Dental Plan.

If your High Deductible Health Plan is the secondary payer, the combined benefit from both plans won’t total more than your High Deductible Health Plan’s limit for the covered charges. Here’s an example of how this works.

Suppose a Chevron employee covers her husband as a dependent under the High Deductible Health Plan. Her husband is also covered by his company’s medical plan. Under the coordination of benefits provisions, the husband’s plan pays first when he has medical expenses (the primary plan). The High Deductible Health Plan pays the remaining covered charges, if any, up to plan limits after the deductible. For example, assume the husband has surgery that requires a three-day hospital stay, the total cost for his surgery is $10,000, all of these charges are covered under the High Deductible Health Plan, and he has already met the $300 deductible. Having used a network provider and hospital under the High Deductible Health Plan, he is eligible for a 90 percent reimbursement (or $9,000). But the primary plan pays $8,000, so the High Deductible Health Plan pays only $1,000.

Note: Coordination of benefits does not apply to benefits payable under any private accident or health insurance plans. Also, it does not apply to benefits payable under any other group insurance or medical
plan maintained by Chevron. However, the plan does coordinate benefits with the Chevron Dental Plan in case of accidental injury to teeth.

**Coordinating Your Children’s Coverage With Your Spouse’s/Domestic Partner’s Plan**

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

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

**Note:** Coordination of benefits does not apply to benefits payable under any private accident or health insurance plans. Also, it does not apply to benefits payable under any other group insurance or medical plan maintained by Chevron. However, the plan does coordinate benefits with the Chevron Dental Plan in case of accidental injury to teeth.

**Your Children’s Coverage if You’re Divorced or Separated**

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

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

**Note:** Coordination of benefits does not apply to benefits payable under any private accident or health insurance plans. Also, it does not apply to benefits payable under any other group insurance or medical plan maintained by Chevron. However, the plan does coordinate benefits with the Chevron Dental Plan in case of accidental injury to teeth.
Coordinating with Medicare

Active employees: If you’re an active employee, and you or an enrolled dependent is eligible for federal Medicare due to age or disability, the High Deductible Health Plan is generally the primary payer and Medicare is the secondary payer.

Note: If you or your dependent has Medicare coverage because of end-stage renal disease, Medicare is primary. However, for the first 30 months of Medicare eligibility, the High Deductible Health Plan is the primary payer and Medicare is secondary. After 30 months, Medicare becomes primary.

Disability Leave: If you’re on leave of absence and receiving Long-Term Disability benefits, the government no longer considers you an active employee. If you become eligible for Medicare due to disability, Medicare becomes the primary payer of benefits for you and any Medicare-eligible dependents. You can remain enrolled in the High Deductible Health Plan, but you must also enroll in Medicare Part B. The High Deductible Health Plan will assume enrollment in both Medicare Part A and Part B and will pay claims as though you have both parts. If you aren’t enrolled in Part B, you will be responsible for a large part of the claims cost.

When you retire, Medicare will become the primary payer for medical benefits. You (and your Medicare-eligible dependents, if applicable) can be covered under the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan or the Chevron Senior Care Plan, instead of under the High Deductible Health Plan. It’s important that Medicare-eligible family members apply for Medicare Part A and Part B three months before your retirement date.
Basic Vision Coverage

If you enroll in the High Deductible Health Plan you are also automatically enrolled in the Vision Program for basic vision coverage with VSP. VSP insures the basic vision benefits under the Vision Program. You and your eligible dependents have basic vision coverage if you are enrolled in the High Deductible Health Plan.
What the Vision Program Pays

If you enroll in the High Deductible Health Plan you are also automatically enrolled in the Vision Program for basic vision coverage with VSP. VSP insures the basic vision benefits under the Vision Program.

<table>
<thead>
<tr>
<th>Network</th>
<th>100% of the comprehensive eye exam, including dilation as needed, per calendar year. Discounts on eyeglasses, contact lenses and accessories are available only from network providers.*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Network</td>
<td>Up to $45 maximum reimbursement per calendar year for a comprehensive eye exam, including dilation as needed.</td>
</tr>
</tbody>
</table>

*Additional coverage for vision materials (such as glasses and contacts) is available through the voluntary Vision Plus benefit. See the Vision Plus Program summary plan description for more information about enrollment and benefits.
Evidence of Coverage Document

VSP is the insurer of the vision benefits provided through the Vision Program. The benefits are governed by the insurance contracts with VSP and are described in the Evidence of Coverage. For a copy of the Evidence of Coverage, contact:

- VSP at 1-800-877-7195.
- Go to www.vsp.com/go/chevron on the Internet.
How to Use Your Basic Vision Benefit

To use your vision benefits, tell your provider you have vision coverage with VSP. You can go to a provider in the VSP network or an out-of-network provider.

For the location of a network vision provider near you, to inquire about the cost to purchase lenses, frames or contact lenses, or to locate a network provider for LASIK or PRK services, call VSP toll-free at 1-800-877-7195, Monday through Friday from 5 a.m. to 8 p.m. Pacific time, on Saturday from 7 a.m. to 8 p.m. Pacific time, and on Sunday from 7 a.m. to 7 p.m. Pacific time. You can also access the VSP website at www.vsp.com/go/chevron.
Basic Vision Claims

A participating network provider will submit claims automatically for you. If you go to an out-of-network provider, contact VSP at 1-800-877-7195 to request information on how to get reimbursed for covered services. Claim forms are also available from the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.) or on the Benefits Connection website at hr2.chevron.com. If you have a dispute with VSP about a claim for benefits or to appeal a denied claim, you should follow VSP’s procedures to resolve your claim. Refer to your Evidence of Coverage for details. To obtain a copy of the Evidence of Coverage contact:

• VSP at 1-800-877-7195.
• Go to www.vsp.com/go/chevron on the Internet.

You must file a claim for payment of benefits no later than 365 days from the date in which service was provided. If you don’t file a proper claim with VSP within this timeframe, benefits for service will be denied.

If your dispute concerns eligibility to participate in the plan, you must follow the procedures described in the How to File a Claim for Eligibility section of this summary plan description.
Prescription Drugs

Express Scripts is the claims administrator of prescription drug benefits under the High Deductible Health Plan. You and your eligible dependents are covered by the Chevron Prescription Drug Program if you are enrolled in the High Deductible Health Plan. This section describes the prescription drug benefits under the plan.
Overview

- Express Scripts is the claims administrator of the Prescription Drug Program. Express Scripts has a network of retail pharmacies and a home delivery pharmacy program.

- You and your eligible dependents are covered by the Chevron Prescription Drug Program if enrolled in the High Deductible Health Plan.

- Under the HDHP, you will pay the full cost of retail and also mail-order prescription drugs until you reach the single combined annual deductible.

- To help control pharmacy costs, the program encourages generic drug usage by charging more when the brand-name version of a drug is chosen over a generic version. If your doctor specifies that you receive a brand-name drug instead of a generic drug (by writing "Dispense as Written" on your prescription), or if you tell the pharmacist that you want a brand-name drug, even when a generic is available, your prescription will be filled with a brand-name drug. After the HDHP combined deductible is reached, you’ll pay a $5 generic copayment plus the difference between the cost of the brand-name drug and the generic drug unless your doctor provides the medical reason that neither the generic version of the drug, or other covered drugs that treat the same condition will work. In that case, you will not pay the difference between the cost of the brand-name drug and the generic drug.

- The Prescription Drug Program also features a list of preferred brand-name drugs designed to help keep costs down.
## Prescription Drug Benefit Overview

The following table gives an overview of the prescription drug benefits under the High Deductible Health Plan (HDHP). It highlights both the retail (network and out-of-network) and home delivery pharmacy service components of the Prescription Drug Program. To receive network prices, you must provide your Prescription Drug Program ID card, or Express Scripts ID number at the time of purchase.

<table>
<thead>
<tr>
<th>Program Feature</th>
<th>Retail Pharmacy (network)</th>
<th>Retail Pharmacy (out-of-network) **</th>
<th>Home Delivery Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>HDHP Deductible</td>
<td>$2,650 You + Only</td>
<td>$2,650 You + Only</td>
<td>$2,650 You + Only</td>
</tr>
<tr>
<td>(combined deductible for medical, prescription drugs, mental health, and substance abuse services)</td>
<td>$5,300 You + One Adult</td>
<td>$5,300 You + One Adult</td>
<td>$5,300 You + One Adult</td>
</tr>
<tr>
<td></td>
<td>$5,300 You + Child(ren)</td>
<td>$5,300 You + Child(ren)</td>
<td>$5,300 You + Child(ren)</td>
</tr>
<tr>
<td></td>
<td>$7,950 You + Family</td>
<td>$7,950 You + Family</td>
<td>$7,950 You + Family</td>
</tr>
<tr>
<td>HDHP Annual Out-of-Pocket Maximum</td>
<td>$5,000 You + Only</td>
<td>$5,000 You + Only</td>
<td>$5,000 You + Only</td>
</tr>
<tr>
<td>(combined out-of-pocket maximum for medical, prescription drugs, mental health, and substance abuse services)</td>
<td>$9,000 You + One Adult</td>
<td>$9,000 You + One Adult</td>
<td>$9,000 You + One Adult</td>
</tr>
<tr>
<td></td>
<td>$9,000 You + Child(ren)</td>
<td>$9,000 You + Child(ren)</td>
<td>$9,000 You + Child(ren)</td>
</tr>
<tr>
<td></td>
<td>$12,900 You + Family</td>
<td>$12,900 You + Family</td>
<td>$12,900 You + Family</td>
</tr>
</tbody>
</table>

**Generic Drugs**
- After you pay the combined deductible, the plan pays:
  - 100% after you pay a $5 copayment.

**Preferred Brand-Name Drugs***
- 80% You pay a $15 minimum.

**Nonpreferred Brand-Name Drugs***
- 70% You pay a $30 minimum.

**Supply Limit**
- Up to a 30-day supply.

**Refills Maintenance Drugs**
- 40% beginning with second refill of maintenance drug.

**Specialty Maintenance Drugs**
- Refills at retail – 0%.

*Generic Drugs vs. Brand-Name Drugs*
If you or your doctor request a brand-name drug when a generic version of the drug is available (at a network or out-of-network pharmacy or through the mail), you pay the generic copayment plus the difference in cost between the brand-name drug and its generic equivalent unless your doctor provides the medical reason that the generic version of the drug will not work.

**Network Pharmacies vs. Out-of-Network Pharmacies**
When you use a retail pharmacy that is out-of-network (or a network pharmacy is unable to verify your eligibility), you pay your coinsurance percentage or copayment (depending on the type of drug prescribed) plus the difference between the network discounted price and the out-of-network price for your prescription.
Covered Medication

Qualification Requirements
For a prescription drug or device to be covered under the Prescription Drug Program, the medication must qualify as follows:

- It must be prescribed on an outpatient basis by a doctor.
- It must be approved by the Federal Food and Drug Administration (FDA).
- It must be dispensed by a licensed pharmacist.
- It cannot be sold over the counter except as required by the Patient Protection and Affordable Care Act.
- It cannot be specifically excluded by the Prescription Drug Program. In addition, the program covers:
  - Insulin, insulin needles and syringes.
  - Diabetic supplies (such as lancets and urine and blood test strips and tapes).

If an existing drug changes or when new drugs are approved by the FDA, they also must meet the above criteria before the drug is covered under the Prescription Drug Program. Furthermore, Chevron has the right to determine which drugs will be covered, limited or excluded under the Prescription Drug Program.

Most kinds of prescription medication are covered under the Prescription Drug Program if the above criteria are met, including the following drugs and supplies:

- Smoking deterrents (covered at 100%, with no deductible).
- Prescribed FDA approved female contraceptive methods including prescribed contraceptives which can be purchased over-the-counter (covered at 100%, with no deductible).
- Prescription vitamins (not over-the-counter), including prenatal vitamins.
- Retin-A, covered up to age 34.
- Needles, syringes and injectable medications.
- Fluoride Supplementation for dependents six months old through age 5 (covered at 100%, with no deductible).
• Doctor prescribed medications for preventive care as required by the Patient Protection and Affordable care Act with no deductible for certain generic over-the-counter drugs and generic prescription drugs. Examples of the medications are:

  – Aspirin to prevent cardiovascular events (men age 45 - 79, women age 55 - 79)
  – Folic Acid (women through age 50)
  – Iron Supplements (children age 6 – 12 months who are at risk for iron deficiency anemia)
  – Vitamin D (men and women over the age of 65 who are at increased risk for falls)
  – Bowel Preps (men and women age 50 – 75); coverage is for generic and single-source prescription drugs and generic over-the-counter products. Limited to a maximum of two prescriptions per 365 days.

For more information about which drugs aren’t covered under the Prescription Drug Program, see Drugs That Aren't Covered in this section.

**Managed Prior Authorization**

*For participants who are not expatriates.*

Drugs within certain therapy classes are covered by the Prescription Drug Program only if prescribed for certain uses or only up to quantity level limitations determined by Express Scripts. Specified drugs in the following therapy classes require Managed Prior Authorization and/or are subject to quantity limits:

• Androgens
• Antinacloptic Agents
• Anti-Nausea
• Antiviral
• Cancer Therapy
• Cryopyrin-Associated Periodic (CAP) Syndrome
• CNS Stimulants and Amphetamines
• COX II Inhibitors
• Dermatologicals
• Erectile Dysfunction
• Erythropoiesis-Stimulating Agents (ESA)
• Growth Hormone, Gonadotropin-Releasing Hormone (GHRH), and Related Agents
• Hormones
• Immune Globulins
• Interferons
• Multiple Sclerosis
• Myeloid Stimulants and Hemostatics
• Migraine
• Neurological
• Osteoporosis
• Paroxysmal Nocturnal Hemoglobinuria (PNH) Agents
• Psoriasis
• Pulmonary Agents
• Respiratory Syncytial Virus (RSV) Agents
• Rheumatoid Arthritis
• Topical Anesthetics

A prescription drug that is a type listed above, but is not specifically named above, may be subject to the Managed Prior Authorization requirements. The current list of prescription drugs that require Managed Prior Authorization and/or are subject to quantity limits can be obtained at any time from Express Scripts.

In addition, compound medications for which the following bulk powders are the primary ingredient also require Managed Prior Authorization:

• Diclofenac
• Flurbiprofen
• Fluticasone
• Gabapentin
• Haluronic Acid
• Ketamine
• Ketoprofen
• Meloxicam
• Mometasone
• Nabumetone
Managed Prior Authorization

*For participants who are expatriates.*

Drugs within certain therapy classes are covered by the Prescription Drug Program only if prescribed for certain uses or only up to quantity level limitations determined by Express Scripts. Specified drugs in the following therapy classes require Managed Prior Authorization and/or are subject to quantity limits:

- Anabolics
- Androgens
- Antifungal
- Antinacoleptic Agents
- Antiviral Agents
- Cancer Therapy
- Dermatologicals (PA after age 34)
- Erythropoiesis-Stimulating Agents (ESA)
- Growth Hormone, Gonadotropin-Releasing Hormone (GHRH), and Related Agents
- Hormones
- Interleukins
- Multiple Sclerosis
- Myeloid Stimulants and Hemostatics
- Neurological Agents
- Paroxysmal Nocturnal Hemoglobinuria (PNH) Agents
- Psoriasis Therapy
- Pulmonary Agents
- Pulmonary Arterial Hypertension
- Sleep Disorders

A prescription drug that is a type listed above, but is not specifically named above, may be subject to the Managed Prior Authorization requirements. The current list of prescription drugs that require Managed Prior Authorization and/or are subject to quantity limits can be obtained at any time from Express Scripts.
In addition, compound medications for which the following bulk powders are the primary ingredient also require Managed Prior Authorization:

- Diclofenac
- Flurbiprofen
- Fluticasone
- Gabapentin
- Haluronic Acid
- Ketamine
- Ketoprofen
- Meloxicam
- Mometasone
- Nabumetone

**Preferred Drug Step Therapy Program**

*For participants who are not expatriates.*

Prescription drugs to treat specified disease states are covered by the Prescription Drug Program only if preferred drugs, including generics, when clinically appropriate, are utilized first. These drugs require authorization of Express Scripts under the Preferred Drug Step Therapy Program. Specified drugs used to treat the following disease states require authorization under the Preferred Drug Step Therapy Program:

- Asthma
- Diabetes
- Glaucoma
- High Blood Pressure
- Infertility
- Insomnia
- Migraine
- Nasal Allergy
- Osteoporosis
- Ulcer
The current list of prescription drugs that require authorization of Express Scripts under the Preferred Drug Step Therapy Program can be obtained at any time from Express Scripts.

For any drugs that require prior authorization, your network pharmacist or Express Scripts home delivery pharmacist can begin the authorization process by contacting your doctor to review the therapy and determine whether the drug can be covered. You and your doctor will be notified when this process is completed. If the medication isn’t approved, you’ll be responsible for paying the full cost of the drug.

Note: Certain controlled substances and several other prescribed medications, including hypnotics (sleeping pills); migraine medications and antifungals, may be subject to dispensing limitations and the professional judgment of the pharmacist. If you have any questions about your medication, please call Express Scripts Member Services at 1-800-987-8368.

Medical Channel Management
Certain specialty drugs that are self-administered are covered by the Prescription Drug Program only if they are ordered through the Express Scripts Specialty Pharmacy, Accredo. They will not be covered if supplied by your doctor or another pharmacy. Examples of some conditions that are subject to Medical Channel Management are:

- Cancer – oral medications
- Growth Stimulating Agents
- Hemophilia – nasal medications
- HIV
- Immune Deficiency
- Infertility
- Metabolic Disorders
- Multiple Sclerosis
- Osteoporosis
- Parkinson’s Disease
- Pulmonary – Cystic Fibrosis
- Rheumatoid Arthritis and other Autoimmune Conditions
- Short Bowel Disease

The list of specialty drugs subject to Medical Channel Management may change so you should check the list before you fill a prescription for a specialty drug. Call 1-800-987-8368 for a complete list of drugs subject to Medical Channel Management.

Home Delivery Pharmacy Requirement for Maintenance Specialty Drugs
The second or later fill of a Specialty Drug that is a maintenance drug (as specified by Express Scripts) is covered after the first fill only if obtained from the Home Delivery Pharmacy Program.
Drugs That Aren’t Covered

The following drugs, supplies and services aren’t covered under the Prescription Drug Program:

- Drugs not listed on the National Preferred Formulary.
- Nonfederal legend drugs, including over-the-counter medications, unless otherwise specified in the Prescription Drug Program as covered.
- Anorexiants and appetite suppressants.
- Topical fluoride products except as required by the Patient Protection and Affordable Care Act.
- Retin-A, Avita and Altinac creams after age 34, unless prior authorization is obtained from Express Scripts.
- Blood glucose testing monitors (covered under the medical portion of the Medical PPO Plans).
- Therapeutic devices or appliances (including durable medical equipment).
- Drugs designed solely to promote or stimulate hair growth (including Rogaine and Propecia) or for cosmetic purposes only (such as Renova).
- Allergy serums (may be covered under another part of the plan).
- Immunization agents and vaccines.
- Biologicals and blood or blood plasma products.
- Drugs designated under federal law for investigational use or as experimental drugs, even if you’re charged for the drugs.
- Refills in excess of the number prescribed by your doctor or dispensed more than one year after your doctor gave you the prescription.
- Drugs that are prescribed as part of your treatment while you are an inpatient in any facility, such as a hospital or skilled nursing facility that has a facility for dispensing drugs on its premises.
- Charges for the administration or injection of any drug.
- Refills of specialty maintenance medications purchased at a retail pharmacy.
- Nonsedating antihistamines.

In addition, charges are covered only if you file your claim within one year after your prescription is filled. Please note that this may be different from the time period to file medical claims.
Networks

When You Go to a Network Pharmacy
You can fill prescriptions for up to a 30-day supply of covered medication at any network pharmacy. Here’s how:

1. Show your prescription ID card to the pharmacist or provide your Express Scripts ID number when you hand in your prescription. Generally, after you meet your deductible, you will pay the following for most drugs:
   — $5 for generic drugs.
   — 20 percent of the discounted cost for preferred brand-name drugs.
   — 30 percent of the discounted cost for nonpreferred brand-name drugs.

   In addition, there is a $15 minimum payment per preferred brand-name drug and a $30 minimum for non-preferred drugs, up to the total cost of the drug.

   You’ll receive a generic version of the drug, unless a generic version is not available. If your doctor specifies that you receive a brand-name drug instead of a generic drug (by writing “Dispense as Written” on your prescription), or if you tell the pharmacist that you want a brand-name drug, even when a generic is available, your prescription will be filled with a brand-name drug. You’ll pay a $5 generic copayment plus the difference between the cost of the brand-name drug and the generic drug unless your doctor provides the medical reason that neither the generic version of the drug, or other drugs that treat the same condition will work. In that case, you will not pay the difference between the cost of the brand-name drug and the generic drug.

   The paragraph above doesn’t apply to covered charges for smoking deterrents and fluoride supplements.

2. The pharmacist will process your prescription, using the program’s computer system to confirm your eligibility and make sure the drug is covered under the plan. The computer system may notify the pharmacist if there’s a potential problem with the prescription (such as a risk of adverse interaction with other drugs you’re taking).

3. To encourage you to use the home delivery pharmacy services when you need maintenance medication, you will pay 60 percent of the cost if you go to a pharmacy for the second refill of a prescription for maintenance medication, with a $5 minimum payment per generic drug and a $15 minimum payment per preferred brand name drug, or $30 minimum for non-preferred brand-name drug, up to the total cost of the drug. This plan provision doesn’t apply to covered charges for smoking deterrents and fluoride supplements.
When You Go to a Pharmacy That’s Out-of-Network
If you go to a pharmacy that’s out-of-network to fill prescriptions for up to a 30-day supply of covered medication, you pay the pharmacist the full price of the prescription and file a claim form.

Once you file the claim, and after you meet your annual deductible, you are generally reimbursed according to the following coinsurance levels for most drugs:

- 100 percent of the discounted cost for generic drugs after a $5 copayment.
- 80 percent of the discounted cost for preferred brand-name drugs.
- 70 percent of the discounted cost for brand-name nonpreferred drugs.

You will not be reimbursed for the difference between the discounted network pharmacy price and the out-of-network pharmacy price for your prescription.

In addition, there is a $15 minimum payment for each 30-day supply of preferred brand-name drugs and $30 minimum payment for non-preferred drugs, up to the total cost of the drug.

In addition, if your doctor specifies that you receive a brand-name drug instead of a generic drug (by writing “Dispense as Written” on your prescription), or if you tell the pharmacist that you want a brand-name drug, even when a generic is available, your prescription will be filled with a brand-name drug. If you choose the brand-name drug when the generic is available, you also pay the difference between the generic and the brand-name drug unless your doctor provides the medical reason that neither the generic version of the drug, or other covered drugs that treat the same condition will work. In that case, you will not pay the difference between the cost of the brand-name drug and the generic drug.

The paragraph above doesn’t apply to covered charges for smoking deterrents and fluoride supplements.

Filing a Claim
If your prescription is filled at an out-of-network pharmacy or at a network pharmacy, but the pharmacist is unable to verify your coverage, you must pay the full price for your medication and send in a completed claim form to request reimbursement of covered charges. If your claim is denied, you’ll be notified in writing. For more information, see the Prescription Drug Claims section.
Home Delivery Pharmacy Program

The Prescription Drug Program’s home delivery pharmacy services are administered by Express Scripts. You can order up to a 90-day supply of covered prescription drugs without a deductible. You should use this part of the program when you need maintenance medication.

When you use the home delivery pharmacy to fill a prescription, you will generally pay the following amounts for each 90-day (or less) supply:

- $15 for generic drugs (up to the total cost of the drug).
- 15 percent for preferred brand-name drugs, with a $35 minimum (up to the total cost of the drug).
- 25 percent for nonpreferred brand-name drugs, with a $75 minimum (up to the total cost of the drug).
- To encourage the use of more cost-effective generics, if you choose a brand-name drug when a generic version of the drug is available, or if your doctor specifies that you receive a brand-name drug by writing “Dispense as Written” on your prescription, you will pay the $15 generic copayment plus the difference between the brand-name and the generic version unless your doctor provides the medical reason that neither the generic version of the drug, or other covered drugs that treat the same condition will work. In that case, you will not pay the difference between the cost of the brand-name drug and the generic drug

The paragraph above doesn’t apply to covered charges for smoking deterrents and fluoride supplements.

Note: Because of the time required for home delivery shipments, this part of the Prescription Drug Program isn’t suitable for one-time prescriptions, for emergencies or for temporary conditions. Allow a minimum of two to three weeks for new prescriptions.

How to Order Medication by Mail

- Ask your doctor for a prescription for a 90-day supply of medication, with up to three refills. You can order a smaller supply, but you’ll still pay the same minimum amount. If you need medication immediately, ask your doctor to write another prescription for a 14-day supply and have it filled at a pharmacy. If your doctor wants to try a new maintenance drug for a brief time, ask for two prescriptions — one for a small supply to monitor the drug’s effectiveness and the second for a 90-day supply with refills. Take the first prescription to a network pharmacy to be filled. After you and your doctor determine that the new drug is effective, send the other prescription to the home delivery pharmacy.

- Your doctor can fax your prescriptions to Express Scripts. Ask your doctor to call 1-888-327-9791 for faxing instructions. Then call Express Scripts Member Services to make sure they have a valid telephone number and shipping address for you.

- If time permits, you can mail your prescriptions to Express Scripts. Please allow a minimum or two to three weeks for delivery. Call Express Scripts Member Services for the home delivery pharmacy address closest to where you want your medications mailed.
• Complete an order form and health assessment questionnaire (for your first order only), included in your information packet or available from Express Scripts Member Services at 1-800-987-8368. You can also request home delivery order forms and envelopes by visiting www.Express-Scripts.com.

• Check your doctor’s prescription form to make sure it includes the correct dosage, your doctor’s signature and your name and address (or your covered dependent’s name and address).

• Write your Prescription Drug Program ID number (found on your prescription ID card) on the back of the prescription slip.

• Use the envelope provided with your order form to send in the original prescription slip, your completed order form and your share of the cost of the drugs. Send your completed health assessment questionnaire in the separate envelope provided. Please allow up to 21 days for delivery. You can request express delivery at an additional cost.

Ordering Prescription Refills by Mail
A reorder form and envelope are included with each prescription you order using the home delivery pharmacy. To order a refill of your prescription, follow the instructions on the reorder form, visit www.Express-Scripts.com or call Express Scripts Member Services at 1-800-987-8368. You should order refills three weeks before your current supply runs out. Prescriptions are valid for up to 12 months. After that, you must ask your doctor for a new prescription.

Note: You can pay your share of home delivery pharmacy costs with a personal check or money order, or you can charge it on your MasterCard, Visa, American Express, Diners or Discover credit card by writing your charge account number and expiration date on the order form. If you do not use a credit card or provide another form of payment when you submit your order, Express Scripts will fill your prescription and send it to you as long as the order is no more than $100. (Express Scripts will bill you later.) If your order is over $100, Express Scripts will not fill your prescription without payment. For an estimate of the cost of your prescription, visit www.Express-Scripts.com or call Express Scripts Member Services at 1-800-987-8368.
Special Vacation Supply of Prescription Medication

If you’re planning to travel and you need medication while you’re away:

- You can call Express Scripts Member Services at 1-800-987-8368 or log on to the website at www.Express-Scripts.com to find out how to arrange for an early refill of your medication. (Vacation supply requests are limited to two per 180 days)

- You can call Express Scripts Member Services to get a list of network pharmacies in the areas you’ll visit.

- You can order the medication you need ahead of time, using the program’s home delivery pharmacy.

- You can go to an out-of-network pharmacy while you’re on vacation and pay the entire cost and file a claim for reimbursement (the benefits under this option will be lower than if you use one of the other options).
Prescription Drug Claims Review and Appeals

This section describes how to file a claim for outpatient prescription drug benefits and the claim review and appeals process that is followed whenever you submit a claim for benefits. You also should be aware that Express Scripts has the right to request repayment if it overpays a claim for any reason. If your dispute concerns eligibility to participate in the plan, you must follow the procedures described in the How to File a Claim for Eligibility section of this summary plan description. (The plan administrator for the Prescription Drug Program determines whether you or a dependent is eligible to participate in the Prescription Drug Program.)

Express Scripts is the claims administrator for the Prescription Drug Program. Express Scripts processes payments for claims, answers questions and reviews appeals according to the plan’s provisions. Express Scripts, as claims administrator, is the named fiduciary that, in its sole discretion, has the authority to interpret plan provisions, as well as facts and other information related to claims and appeals of outpatient prescription drug claims.

How to File a Prescription Drug Claim

If your prescriptions are filled at a network pharmacy or through the program’s home delivery pharmacy, you pay your share of the cost when you order the medication you need. There are no claim forms to fill out.

However, if your prescription is filled at an out-of-network pharmacy or at a network pharmacy but your request is denied (for example, your ID card is rejected), you pay the full price charged for your medication and send in a completed claim form to request reimbursement of covered charges. You must file your claim form within one year after your prescription is filled. (Please note that this is different from the time period to file claims under the HDHP) Otherwise, no benefits will be payable for that prescription. If you don’t file a proper claim with Express Scripts within this time frame, benefits will be denied.

To request a claim form, you can call Express Scripts Member Services at 1-800-987-8368 or you can obtain forms from Express Scripts’ website at www.Express-Scripts.com. Claim forms are also available on the Benefits Connection website at hr2.chevron.com or from the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.) When you fill out the claim form, use your full name and member ID number located on your Express Scripts ID card. Attach the original receipt from the pharmacy. The receipt must contain the following information:

- Date prescription was filled.
- Name and address of the pharmacy.
- National Drug Code (NDC) number.
- Name of drug and strength.
- Quantity.
- Prescription (Rx) number.
- “Dispense as Written,” if applicable.
- Amount paid for the medication.
Mail the completed claim form to the address shown on the form.

If your claim is denied (in whole or in part), or if Express Scripts needs more information before it can approve your claim, you’ll be notified in writing. When a claim is denied, you can appeal the denial as described below.

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 summary plan description.

**Note:** For information on how to file a medical benefit claim, see the Medical Coverage section of this summary plan description. For information about basic vision claims, see the Basic Vision section of this summary plan description.

**Initial Review and Decision**

**Claims for Prior Authorization and Dispense as Written (DAW) Prescription Drug Benefits**

Express Scripts reviews all claims for prescription drugs that require prior authorization and for prescriptions for which your doctor requests “Dispense as Written.” When a prescription falls within these categories and you present it at a retail network pharmacy or submit it to the home delivery pharmacy, this information is electronically transmitted to Express Scripts. On behalf of the Prescription Drug Program and according to the Prescription Drug Program’s provisions, Express Scripts will make a benefit determination within the following time limits:

- **Retail Network Pharmacy**
  Within 15 days of receipt of the request for coverage, Express Scripts will make a determination on a prescription presented at a retail network pharmacy. If additional information is required to make the determination, a fax will be sent to the prescribing doctor requesting the necessary information. If the required information is not received within 45 days, the claim will be denied based on lack of information.

- **Home Delivery Pharmacy**
  Within 15 days of receipt of the request for coverage, Express Scripts will make a determination on a prescription submitted to the home delivery pharmacy. If additional information is required to make the determination, the prescribing doctor will be contacted by fax or phone with a request for the necessary information. If the required information is not received within 45 days, the claim will be denied based on lack of information.
Urgent Care Claims
An urgent care claim is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or which, in the opinion of your doctor, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If your coverage request is an urgent care claim, Express Scripts will make a determination on a prescription presented at a retail network pharmacy or submitted to the home delivery pharmacy not later than 72 hours after receiving the initial claim, if it was properly made and no additional information is required. If additional information is required to make the determination, the prescribing doctor will be contacted by fax or phone with a request for the necessary information. Your doctor will have 48 hours to provide the additional information requested. In this case, Express Scripts will make a determination not later than 48 hours after receiving the additional information or after the expiration of the 48-hour deadline to provide such information, whichever is earlier.

Claims for Other Prescription Drug Benefits
If you present a prescription for a drug that does not require prior authorization or for a drug for which your doctor has not requested “Dispense as Written,” either at a retail pharmacy or through the home delivery pharmacy, and your request is denied, you can contact Express Scripts for an explanation. If you are not satisfied with the explanation provided by Express Scripts, you can file a claim for benefits by writing to Express Scripts at the following address:

Express Scripts
P.O. Box 631850
Irving, TX 75063-0030

Your claim will be processed within the time limits set forth in the chart below, Time Limits for Processing Prescription Drug Appeals.

If your claim is approved, benefits will be paid to the pharmacy unless you have already paid for the prescription drug, in which case benefits will be payable to you. When a written claim is denied, you can appeal the denial.
If Your Prescription Drug Claim Is Denied
If your prescription drug claim is denied (in whole or in part), you will receive a written notice from Express Scripts that includes all of the following:

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

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

If your claim for benefits is denied based on medical necessity or experimental treatment or a similar exclusion or limit, the notice must include an explanation of the scientific or clinical judgment for the determination. It also must apply the terms of the plan to your medical circumstances. Alternatively, the notice will include a statement that such explanation will be provided to you free of charge upon request.
How to File an Appeal
This section describes how to file an appeal with Express Scripts and the time limits that apply to the different types of prescription drug appeals.

<table>
<thead>
<tr>
<th>Time Limits</th>
<th>Types of Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urgent Care Prescription Drug Claims</td>
</tr>
<tr>
<td>Your deadline to file a first appeal</td>
<td>180 days after receiving the claim denial notice.</td>
</tr>
<tr>
<td>Plan notice of first appeal decision</td>
<td>Not later than 72 hours after receiving an appeal.</td>
</tr>
<tr>
<td>Your deadline to file a second appeal</td>
<td>N/A</td>
</tr>
<tr>
<td>Plan notice of second appeal decision</td>
<td>N/A</td>
</tr>
<tr>
<td>Your deadline to request an External Review</td>
<td>Four months after receiving the appeal denial notice.</td>
</tr>
<tr>
<td>IRO notice of External Review Decision</td>
<td>Not later than 72 hours after receiving the request for external review.</td>
</tr>
<tr>
<td></td>
<td>All Other Prescription Drug Claims (except member-submitted paper claims)</td>
</tr>
<tr>
<td></td>
<td>180 days after receiving the claim denial notice.</td>
</tr>
<tr>
<td>Plan notice of first appeal decision</td>
<td>Not later than 15 days after receiving an appeal.</td>
</tr>
<tr>
<td></td>
<td>90 days after receiving the first appeal denial notice.</td>
</tr>
<tr>
<td>Plan notice of second appeal decision</td>
<td>Not later than 15 days after receiving a second appeal.</td>
</tr>
<tr>
<td>Your deadline to request an External Review</td>
<td>Four months after receiving the second appeal denial notice.</td>
</tr>
<tr>
<td>IRO notice of External Review Decision</td>
<td>Not later than 45 days after receiving the request for external review.</td>
</tr>
<tr>
<td></td>
<td>Member-Submitted Paper Claims for Prescription Drugs</td>
</tr>
<tr>
<td></td>
<td>180 days after receiving the claim denial notice.</td>
</tr>
<tr>
<td>Plan notice of first appeal decision</td>
<td>Not later than 30 days after receiving an appeal.</td>
</tr>
<tr>
<td></td>
<td>90 days after receiving the first appeal denial notice.</td>
</tr>
<tr>
<td>Plan notice of second appeal decision</td>
<td>Not later than 30 days after receiving a second appeal.</td>
</tr>
<tr>
<td>Your deadline to request an External Review</td>
<td>Four months after receiving the second appeal denial notice.</td>
</tr>
<tr>
<td>IRO notice of External Review Decision</td>
<td>Not later than 45 days after receiving the request for external review.</td>
</tr>
</tbody>
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First Appeal
After receiving the notice of denial, you or your authorized representative (this can be your provider, your beneficiary, your legal representative or another appropriately authorized individual) may ask for an appeal, which is a full and fair review of the initial claim decision, by writing to Express Scripts. Your first appeal must be submitted in writing within 180 days after the claim is denied.

During the time limit for requesting a first appeal, you or your authorized representative will be given reasonable access to all documents and information (other than legally or medically privileged documents) relevant to the claim, and you may request copies free of charge. You may also request to review the claim file. You also can submit written comments, documents, records and other information pertinent to your claim to Express Scripts.

Your written first appeal should include the following information:

- Your full name even if the claim is for your dependent.
- Your member ID number located on your Express Scripts ID card.
- Your phone number.
- The prescription drug for which coverage has been denied.
- An explanation of why you believe the prescription drug should be covered.
- Any supporting information or documentation.

For a prescription drug claim only, send your written request for a first appeal to:

Express Scripts
P.O. Box 631850
Irving, TX 75063-0030

If your urgent care claim is denied, you have the right to request an urgent appeal of the adverse determination. Urgent appeal requests may be oral or written. You or your doctor can call 1-800-987-8368 or send a written appeal request to the above address. In the case of an appeal for coverage involving an urgent care claim, you will be notified of the benefit determination within 72 hours of receipt of the appeal. This coverage decision is final and binding. There is only one level of internal appeal for an urgent care claim, but you may request an expedited external review of a denial of an appeal involving urgent care.
Time Limits and Procedures for Processing Your First Appeal
Upon receipt of your first appeal, Express Scripts will review the claim again and make a decision based on all comments, documents, records and other information you've submitted, without regard to whether such information was submitted or considered in the initial benefit determination. Express Scripts will make its determination on your first appeal in accordance with the time limits shown in the chart, Time Limits for Processing Prescription Drug Appeals. The review on appeal will not afford deference to the initial denial, and it will be conducted by a fiduciary who is neither the individual who initially denied the claim that is the subject of the appeal nor the subordinate of such individual.

If Express Scripts considers, relies upon or generates any additional or new evidence during the appeal or if Express Scripts will base an impending denial upon any new or additional rationale, Express Scripts will provide such evidence or rationale as soon as possible in advance of the date the decision is due in order to give you a reasonable opportunity to respond prior to the decision being issued

Notice of Decision on First Appeal
If, on first appeal, Express Scripts determines that your explanation and additional information support the payment of your claim, Express Scripts will process your prescription and benefits will be paid to the pharmacy, unless you have already paid for the prescription drug, in which case benefits will be payable to you.

If your first appeal is denied (in whole or in part), you will receive a written notice. The notice will contain information sufficient to identify the claim involved. The notice will state the reasons for the denial, including references to specific plan provisions upon which the denial was based and a statement of your right to file a civil lawsuit under Section 502(a) of ERISA following an adverse determination after completion of all levels of appeal/review required by the plan. The notice will state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

If, on first appeal, Express Scripts upholds the denial of your claim, you may file a second appeal within 90 days after receiving the notice of denial of your first appeal. However, there is only one level of internal appeal for an urgent care claim.

Sometimes a claim or appeal is denied based on an internal rule, guideline, protocol or other similar item. If this happens, the notice will include a copy of the rule, guideline, protocol or item that was relied on to deny the claim. Alternatively, the notice will include a statement that an internal rule, guideline, protocol or similar item was relied on to deny your claim, and that 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 circumstances. Alternatively, the notice will include a statement that such explanation will be provided to you free of charge upon request.

The notice will include any additional information required by Department of Labor claim, appeal and external review regulations.

Express Scripts is the named fiduciary that serves as the review committee and, in its sole discretion, has the authority to interpret plan provisions, as well as facts and other information related to claims for which a first appeal is requested.
Second Appeal
After receiving the notice of denial of your first appeal, you or your authorized representative (this can be your provider, your beneficiary, your legal representative or another appropriately authorized individual) may ask for a second appeal.

During the time limit for requesting a second appeal, you or your authorized representative will be given reasonable access to all documents and information (other than legally or medically privileged documents) relevant to the claim, and you may request copies free of charge. You may also request to review the claim file. You also can submit written comments, documents, records and other information or testimony pertinent to your claim to Express Scripts.

Your second appeal must be submitted in writing within 90 days after your first appeal is denied. Your written second appeal should include the following information:

- Your full name even if the claim is for your dependent.
- Your member ID number located on your Express Scripts ID card.
- Your phone number.
- The prescription drug for which coverage has been denied.
- An explanation of why you believe the prescription drug should be covered.
- Any supporting information or documentation.

The second appeal should also include any additional information that wasn't previously submitted with your first appeal, as well as an explanation supporting your position.

For a prescription drug claim only, send your written request for a second appeal to:

Express Scripts
P.O. Box 631850
Irving, TX  75063-0030

Time Limits and Procedures for Processing Your Second Appeal
Upon receipt of your second appeal, Express Scripts will review the claim again and make a decision based on all comments, documents, records and other information you’ve submitted, without regard to whether such information was submitted or considered in the initial benefit determination. Express Scripts will make its determination on your second appeal in accordance with the time limits shown in the chart, Time Limits for Processing Appeals, in this section.

The review on second appeal will not afford deference to the initial denial, and it will be conducted by a fiduciary who is neither the individual who denied the claim or first appeal nor the subordinate of such individuals.

The second appeal will follow the same procedural steps as described for the first appeal.
If Express Scripts considers, relies upon or generates any additional or new evidence during the appeal or if Express Scripts will base an impending denial upon any new or additional rationale, Express Scripts will provide such evidence or rationale as soon as possible in advance of the date the decision is due in order to give you a reasonable opportunity to respond prior to the decision being issued.

**Notice of Decision on Second Appeal**

If, on second appeal, Express Scripts determines that your explanation and additional information support the payment of your claim, Express Scripts will process your prescription and benefits will be paid to the pharmacy, unless you have already paid for the prescription drug, in which case benefits will be payable to you.

If your second appeal is denied (in whole or in part), you will receive a written notice. The notice will contain information sufficient to identify the claim involved. 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 after all levels of required appeals/reviews have been exhausted. The notice will explain how to request an external review.

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.

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

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

The notice will include any additional information required by Department of Labor claim, appeal, and external review regulations.

Express Scripts is the named fiduciary that serves as the final review committee and, in its sole discretion, has the authority to interpret plan provisions, as well as facts and other information related to claims for which a second appeal is requested.
Requesting an External Review

If your second appeal is denied, you may have the right to request an external review. An external review will be provided only when the claim denial involved medical judgment (for example, a denial the plan’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit or a determination that a treatment is experimental or investigational) or the matter is a rescission of coverage.

A de minimis (small) deviation from strict adherence to the internal claims and appeals procedure on the part of the relevant claims administrator or review panel that does not cause, or is not likely to cause, prejudice or harm to the claimant will not waive the requirement to exhaust the internal claims and review procedure before obtaining an external review or filing a lawsuit. The claims administrator shall provide an explanation of such deviation within 10 days of the request of the claimant. If a request for external review is denied on account of the failure to exhaust the internal claims and appeals process when a de minimis deviation is involved, the claimant shall have the right to pursue the internal process.

You or your authorized representative can request an external review in writing or verbally to Express Scripts by following instructions in your denial letter or contacting Express Scripts at:

Attn:  External Review Requests
Express Scripts
P.O. Box 631850
Irving, TX  75063-0030

1-800-753-2851
1-888-235-8551 (fax)

You must request the external review within four months after the date of receipt of a denial of your second appeal. Express Scripts will provide an external review procedure through an accredited Independent Review Organization (IRO) after determining the following:

- You were covered under the plan at the time the services were provided.
- The claim denial is not a result of failure to meet the requirements for eligibility under the plan.
- You have exhausted the appeal process described above.

Within one business day of completing the preliminary review, Express Scripts will notify you in writing of the name and contact information for the IRO reviewing your request for external review. The notice will state that you may submit, in writing, to the IRO within 10 business days, any additional information that you want the IRO to consider when conducting the external review.

Within five business days after the date of assignment to the IRO, Express Scripts will provide to the IRO the documents and any information considered in making the adverse benefit determination and the terms of the Prescription Drug Program.

The IRO will conduct an external review of an adverse benefit determination and issue a final external review decision. The IRO will communicate its external review decision to you and to Express Scripts. If the IRO determines that your explanation and additional information support the payment of your claim, Express Scripts will immediately provide coverage or payment of the claim. If your external review is denied, you will receive a written notice from the IRO within 45 days.
Expediting External Review

You may request an expedited external review if any of the following apply:

- Your urgent care appeal is denied.

- The denial of your claim or appeal involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function.

- You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health, or if the final internal decision on review concerns an admission, availability of care, continued stay, or health care item or service, for which you received emergency services but have not been discharged from a facility.

To request an expedited external review, contact Express Scripts:

Attn: External Review Requests
Express Scripts
P.O. Box 631850
Irving, TX 75063-0030

1-800-753-2851
1-888-235-8551 (fax)

Administrative Power and Responsibilities

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

Coordination of benefits is a feature used to determine how much the Prescription Drug Program pays when you or one of your dependents is covered by more than one group prescription drug plan and incur covered charges for prescription drugs. This feature is designed to prevent overpayment of benefits. This section does not apply to medical coverage or the basic vision coverage under the HDHP.

How It Works
Under the coordination of benefits rules, one plan pays benefits first (the primary payer) and one plan pays second (the secondary payer). The primary payer pays the benefits provided by its plan features. The secondary payer then pays any excess amounts required to bring the total benefits paid up to the levels payable under its plan. The sum of the benefits paid from each plan will not exceed the actual expense incurred.

Coordination of Benefits Under the Prescription Drug Program
If you or one of your dependents is covered by more than one group medical plan when you use the home delivery pharmacy or when you present your Prescription Drug Program ID card at a network retail pharmacy, Express Scripts will cover the drug as if it is the primary payer, regardless of which plan is primary, and you don’t have to submit a claim form. However, if you or one of your dependents is covered by more than one health care plan and does not utilize the home delivery pharmacy or present a Prescription Drug Program ID Card at a retail pharmacy then this Prescription Drug Program is the secondary plan, or if you want the Prescription Drug Program to be the secondary payer, you must submit a claim form, along with the documentation requested on the form to Express Scripts. Be sure to indicate that you are requesting reimbursement under the coordination of benefits feature.

In this case, provided you or your dependent, as applicable, has met the deductible requirement under this Prescription Drug Program, if allowable medical expenses exceed the amount covered by all primary plans, the benefit under this Prescription Drug Program will be the lesser of the amount submitted or what the primary plan(s) did not pay for the prescription drug, up to the maximum amount this Prescription Drug Program would have paid if this Prescription Drug Program were the primary plan. Any Prescription Drug Program co-insurance requirements also apply. Under no circumstances will the sum of the benefits paid from each plan exceed the actual expense incurred.

Note: Coordination of benefits does not apply to benefits payable under any private accident or health insurance plans. Also, it does not apply to benefits payable under any other group insurance or health care plan maintained by Chevron. However, the plans do coordinate benefits with the Dental Plan in case of accidental injury to teeth.
If You or a Dependent Is Covered by More Than One Plan

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

- It doesn’t have a coordination of benefits rule.

- It covers the individual as an eligible employee or retiree (while your HDHP covers the individual as a dependent).

- It covers the individual as an employee (while your HDHP covers the individual as an eligible retiree).

- It has covered the individual longer than your HDHP (if the other conditions in this bulleted list don’t apply).

- It’s the Chevron Dental Plan.

If your HDHP is the secondary payer, the combined benefit from both plans won’t total more than your HDHP’s limit for the covered charges. Here’s an example of how this works.

Suppose a Chevron employee covers her husband as a dependent under the HDHP. Her husband is also covered by his company’s medical plan. Under the coordination of benefits provisions, the husband’s plan pays first when he has medical expenses (the primary plan). The HDHP pays the remaining covered charges, if any, up to plan limits after the deductible. For example, assume the husband has surgery that requires a three-day hospital stay, the total cost for his surgery is $10,000, all of these charges are covered under the HDHP, and he has already met the $300 deductible. Having used a network provider and hospital under the HDHP, he is eligible for a 90 percent reimbursement (or $9,000). But the primary plan pays $8,000, so the HDHP pays only $1,000.

Note: Coordination of benefits does not apply to benefits payable under any private accident or health insurance plans. Also, it does not apply to benefits payable under any other group insurance or medical plan maintained by Chevron. However, the plan does coordinate benefits with the Dental Plan in case of accidental injury to teeth.
Coordinating Your Children’s Coverage With Your Spouse’s/Domestic Partner’s Plan
If you’re covered by the HDHP and your spouse/domestic partner is covered by another group plan (and the other group health plan has a coordination of benefits rule), special rules apply to dependent children covered under both plans:

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

Note: Coordination of benefits does not apply to benefits payable under any private accident or health insurance plans. Also, it does not apply to benefits payable under any other group insurance or medical plan maintained by Chevron. However, the plan does coordinate benefits with the Dental Plan in case of accidental injury to teeth.

Your Children’s Coverage if You’re Divorced or Separated
When parents are separated or divorced or living apart due to termination of a domestic partnership, and children are covered under more than one health care plan and there is no court order to the contrary, the following rules apply:

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

Note: Coordination of benefits does not apply to benefits payable under any private accident or health insurance plans. Also, it does not apply to benefits payable under any other group insurance or medical plan maintained by Chevron. However, the plan does coordinate benefits with the Dental Plan in case of accidental injury to teeth.
Coordinating with Medicare

Active employees: If you’re an active employee and you or an enrolled dependent is eligible for federal Medicare due to age or disability, the HDHP is generally the primary payer and Medicare is the secondary payer.

Note: If you or your dependent has Medicare coverage because of end-stage renal disease, Medicare is primary. However, for the first 30 months of Medicare eligibility, the HDHP is the primary payer and Medicare is secondary. After 30 months, Medicare becomes primary.

Disability Leave: If you’re on leave of absence and receiving Long-Term Disability benefits, the government no longer considers you an active employee. If you become eligible for Medicare due to disability, Medicare becomes the primary payer of benefits for you and any Medicare-eligible dependents. You can remain enrolled in the HDHP, but you must also enroll in Medicare Part B. The HDHP will assume enrollment in both Medicare Part A and Part B and will pay claims as though you have both parts. If you aren’t enrolled in Part B, you will be responsible for a large part of the claims cost.

When you retire, Medicare will become the primary payer for medical benefits. You (and your Medicare-eligible dependents, if applicable) can be covered under the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan or the Chevron Senior Care Plan, instead of under the HDHP. It’s important that Medicare-eligible family members apply for Medicare Part A and Part B three months before your retirement date.
How to File a Claim for Eligibility

If you have been denied participation or if you believe you are entitled to credit for health and welfare eligibility service in the Omnibus Health Care Plan, this section describes how to file a written claim with the plan administrator.
If you have a question regarding your eligibility to participate in the Omnibus Health Care Plan or if you believe you are entitled to credit for health and welfare eligibility service, contact the HR Service Center at 1-888-825-5247, option 2 (610-669-8595 outside the U.S.). If you are not satisfied with the outcome, you can file a claim by following the procedures described below. If you have been denied participation or if you believe you are entitled to credit for health and welfare eligibility service in the Omnibus Health Care Plan, you can file a written claim with the plan administrator. Include the grounds on which your claim is based and any documents, records, written comments or other information you feel will support the claim. Address your written correspondence to:

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

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

- Specific reasons for the denial, as well as the specific Omnibus Health Care Plan provisions or Chevron policy on which the denial is based.

- A description of any additional information that could help you complete the claim and reasons why the information is needed.

- Information about how you can appeal the denial of the claim.

- A statement explaining your right to file a civil lawsuit under Section 502(a) of ERISA if your appeal is denied.
Appeal Procedures for Denied Claims
Regarding Eligibility to Participate or Credit for Health and Welfare Eligibility Service

If your claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan is denied, in whole or in part, and you want to appeal the denial, you must file an appeal within 90 days after you receive written notice of the denial of your claim. The appeal must be in writing, must describe all of the grounds on which it is based and should include any documents, records, written comments or other information you feel will support the appeal. Before submitting the appeal, you can review and receive, at no charge, copies of Omnibus Health Care Plan documents, records and other information relevant to your claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan. The Review Panel will provide you with a written response to the appeal and will either reverse the earlier decision and permit participation or provide credit for health and welfare eligibility service in the Omnibus Health Care Plan, or it will deny the appeal. If the appeal is denied, the written response will contain:

- The specific reasons for the denial and the specific Omnibus Health Care Plan provisions or Chevron policy on which the denial is based.

- Information explaining your right to review and receive, at no charge, copies of Omnibus Health Care Plan documents, records and other information relevant to your claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan.

- A statement explaining your right to file a civil lawsuit under section 502(a) of ERISA.

The Review Panel doesn’t have the authority to change Omnibus Health Care Plan provisions or Chevron policy or to grant exceptions to the Omnibus Health Care Plan rules or Chevron policy. For appeals regarding participation or credit for health and welfare eligibility service in the Omnibus Health Care Plan, address your written correspondence to:

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

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

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

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

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

Employer Identification Number (EIN)
The employer identification number is 94-0890210.

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

Chevron Corporation
P.O. Box 6075
San Ramon, CA 94583-0767
1-888-825-5247 (610-669-8595 outside the U.S.)

Chevron Corporation High Deductible Health Plan
(Administered by United Healthcare)
(includes coverage under the Prescription Drug Program) This plan is part of the Omnibus Health Care Plan.

Plan number: 560
Claims Administrator:
UnitedHealthcare Group Claims – Chevron | Group #247848 | P.O. Box 30555 | Salt Lake City, UT 84130-0555 | www.myuhc.com
Type of Administration: Contract Administration
Type of Plan: Medical Benefit

Chevron Corporation Prescription Drug Program
This program is part of the High Deductible Health Plan and Omnibus Health Care Plan.

Plan number: 560
Claims Administrator:
Express Scripts | One Express Way | St. Louis, MO 63121 | www.Express Scripts.com
Type of Administration: Contract Administration
Type of Plan: Medical (Prescription Drug) Benefit
Chevron Corporation Vision Program
The Vision Program includes Basic Vision coverage and the voluntary Vision Plus Program.

Plan number: 560
Insurer:
P.O. Box 997105 ǀ Sacramento, CA 95899-7105 ǀ www.vsp.com
Type of Administration: Insurer Administration
Type of Plan: Vision Benefit

Chevron Corporation Omnibus Health Care Plan

Plan number: 560
Type of Administration: Contract Administration
Type of Plan: Health Plan

Before-Tax Contribution Plan

Plan number: 721
Type of Administration: Company Administered
Type of Plan: Health Contribution (Section 125 Cafeteria Plan)

Agent for Service of Legal Process
Any legal process related to the plans should be served on:

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

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

If you have a dispute with a health maintenance organization (HMO), a dental health maintenance organization (DHMO), or VSP (for the vision program) regarding benefits or claims, then any legal action should be directed to the agent for service of legal process appointed by the HMO, DHMO, or VSP, as applicable.

For information about the procedure for a QMCSO, please contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).
Administrative Power and Responsibilities
Chevron Corporation has the discretionary authority to control and manage the administration and operation of the Omnibus Health Care Plan (the “Plan”). Chevron Corporation shall have the full, exclusive and discretionary authority to prescribe such forms; make such rules, regulations, interpretations and computations; construe the terms of the Plan; determine all issues relating to coverage and eligibility for benefits; and take such other action to administer the Plan as it may deem appropriate in its sole discretion. Chevron Corporation’s rules, regulations, interpretations, computations and actions shall be final and binding on all persons. Such discretionary authority can also be exercised by a delegate.

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 Omnibus Health Care Plan, provided both of the following apply:

- Your collective bargaining agreement allows for your participation.
- You meet the plan’s eligibility requirements.

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

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

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

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

Incorrect Computation of Benefits
If you believe that the amount of the benefit you receive from the plan is incorrect, you should notify the appropriate 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.
Recovery of Overpayments
An "overpayment" is any payment made to you and/or your covered dependent (or elsewhere for the benefit of you and/or your covered dependent) in excess of the amount properly payable under the health plans. Upon any overpayment, the health plans shall have a first right of reimbursement and restitution with an equitable lien by contract in such amount.

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

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

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

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

No Right to Employment
Nothing in your benefit plans gives you a right to remain in employment or affects Chevron’s right to terminate your employment at any time and for any reason (which right is hereby reserved).

Future of the Plans
Chevron Corporation has the right to change or terminate a plan, including this Plan, at any time and for any reason. A change also may be made to premiums and future eligibility for coverage, and may apply to those who retired in the past, as well as those who retire in the future.

Medical claims incurred before the effective date of a plan change or termination won’t be affected. Claims incurred after a plan is terminated won’t be covered.

If a self-funded plan can’t pay all of the incurred claims and plan expenses as of the date the plan is changed or terminated, Chevron Corporation will make sufficient contributions to the self-funded plan to make up the difference.

If all claims and expenses are paid and Chevron Corporation’s book reserve established for the purpose of making contributions toward the cost of employees’ health care coverage retains a balance, Chevron Corporation will determine what to do with the excess amount in view of the purposes of the plans.
HIPAA

The 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 section and the documents governing the plan.

If You Have a Pre-existing Condition

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

• You lose coverage under the plan.

• You become entitled to elect continuation coverage.

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

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

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

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

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

- If you request a copy of the plan documents or the plan’s latest annual report and do not receive them within 30 days, you can file a civil lawsuit under Section 502(a) of ERISA in a federal court. In such a case, the court can require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials — unless the materials were not sent because of reasons beyond the control of the plan administrator.

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

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

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

If you file suit, the court decides who should pay court costs and legal fees. If you’re successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees — for example, if it finds your claim is frivolous.
Assistance With Your Questions
If you have any questions about the plan, you should contact the claims administrator and/or plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You also can obtain certain publications about your rights and responsibilities under ERISA by:

- Calling the Employee Benefits Security Administration publications hotline at 1-866-444-3272.

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

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

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

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

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

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

**Newborns’ and Mothers’ Health Protection Act of 1996**
In accordance with the Newborns’ and Mothers’ Health Protection Act of 1996, the plan may not restrict benefits for a mother’s or newborn child’s hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, the law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable) following delivery.

**Reconstructive Surgery and Procedures**
Consistent with the Women’s Health and Cancer Rights Act of 1998, if you have a mastectomy and elect reconstructive surgery in connection with the mastectomy, coverage is provided for all of the following:

- Reconstruction of the breast on which the mastectomy is performed.
- Reconstruction and surgery of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment remedies for physical complications during all stages of the mastectomy, including lymphedemas.

You may need to contact Personal Health Support before any reconstructive surgery to make sure you qualify for full benefits. See the Health Care Review section for more information.
Free or Low-Cost Health Coverage to Children and Families
Offered by Medicaid and the Children’s Health Insurance Program (CHIP)

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

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

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

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

**If you have any questions**
Please call the HR Service Center toll-free at 1-888-825-5247 (610-669-8595 outside the U.S.) to speak with a Customer Service Representative. Customer Service Representatives are available from 6 a.m. to 5 p.m., Pacific time (8 a.m. to 7 p.m., Central time), Monday through Friday, except on holidays.
If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2015. Contact your State for more information on eligibility.

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>GEORGIA – Medicaid</th>
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<tr>
<td>Website: <a href="http://www.myalhipp.com">www.myalhipp.com</a></td>
<td>Website: <a href="http://dch.georgia.gov/">http://dch.georgia.gov/</a></td>
</tr>
<tr>
<td>Phone: 1-855-692-5447</td>
<td>- Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 404-656-4507</td>
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<tr>
<th>ALASKA – Medicaid</th>
<th>INDIANA – Medicaid</th>
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<tr>
<td>Website: <a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">link</a> Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529</td>
<td>Website: <a href="http://www.in.gov/fssa">http://www.in.gov/fssa</a> Phone: 1-800-889-9949</td>
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<th>COLORADO – Medicaid</th>
<th>IOWA – Medicaid</th>
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<tr>
<td>Medicaid Website: <a href="http://www.colorado.gov/hcpf">link</a> Medicaid Customer Contact Center: 1-800-221-3943</td>
<td>Website: <a href="http://www.dhs.state.ia.us/hipp/">link</a> Phone: 1-888-346-9562</td>
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<tr>
<th>FLORIDA – Medicaid</th>
<th>KANSAS – Medicaid</th>
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<tr>
<td>Website: <a href="https://www.flmedicaidtplrecovery.com/">link</a> Phone: 1-877-357-3268</td>
<td>Website: <a href="http://www.kdheks.gov/hcf/">link</a> Phone: 1-800-792-4884</td>
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<th>KENTUCKY – Medicaid</th>
<th>NEW HAMPSHIRE – Medicaid</th>
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<tr>
<td>Website: <a href="http://chfs.ky.gov/dms/default.htm">link</a> Phone: 1-800-635-2570</td>
<td>Website: <a href="http://www.dhhs.nh.gov/oii/documents/hippapp.pdf">link</a> Phone: 603-271-5218</td>
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<tr>
<th>LOUISIANA – Medicaid</th>
<th>NEW JERSEY – Medicaid and CHIP</th>
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<tr>
<td>Website: <a href="http://dhh.louisiana.gov/index.cfm/subhome/1/n/331">link</a> Phone: 1-888-695-2447</td>
<td>Medicaid Website: <a href="http://www.state.nj.us/humanservices/">link</a> dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: <a href="http://www.njfamilycare.org/index.html">link</a> CHIP Phone: 1-800-701-0710</td>
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<tr>
<th>MAINE – Medicaid</th>
<th>NEW YORK – Medicaid</th>
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<td>Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">link</a> Phone: 1-800-977-6740 TTY 1-800-977-6741</td>
<td>Website: <a href="http://www.nyhealth.gov/health_care/medicaid/">link</a> Phone: 1-800-541-2831</td>
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<tr>
<td>State</td>
<td>Medicaid and CHIP Services</td>
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<td>------------------------</td>
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| **MASSACHUSETTS**      | Website: http://www.mass.gov/MassHealth  
                           Phone: 1-800-462-1120 |
| **MINNESOTA**          | Website: http://www.dhs.state.mn.us/id_006254  
                           Click on Health Care, then Medical Assistance  
                           Phone: 1-800-657-3739 |
| **MISSOURI**           | Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm  
                           Phone: 573-751-2005 |
| **MONTANA**            | Website: http://medicaid.mt.gov/member  
                           Phone: 1-800-694-3084 |
| **NEBRASKA**           | Website: www.ACCESSNebraska.ne.gov  
                           Phone: 1-855-632-7633 |
| **NEVADA**             | Medicaid Website: http://dwss.nv.gov/  
                           Medicaid Phone: 1-800-992-0900 |
| **SOUTH CAROLINA**     | Website: http://www.scdhhs.gov  
                           Phone: 1-888-549-0820 |
| **SOUTH DAKOTA**       | Website: http://dss.sd.gov  
                           Phone: 1-888-828-0059 |
| **SOUTH DAKOTA - Medicaid** | Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm  
                           Medicaid Phone: 1-800-432-5924  
                           CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm  
                           CHIP Phone: 1-855-242-8282 |
| **WASHINGTON**         | Website: http://hca.wa.gov/medicaid/premiumpyt/pages/index.aspx  
                           Phone: 1-800-562-3022 ext. 15473 |
| **WEST VIRGINIA**      | Medicaid Website: http://www.hca.wa.gov/medicaid/premiumpyt/pages/index.aspx  
                           Phone: 1-800-562-3022 ext. 15473 |
| **VIRGINIA**           | Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm  
                           Medicaid Phone: 1-800-432-5924  
                           CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm  
                           CHIP Phone: 1-855-242-8282 |
| **WISCONSIN**          | Website: http://www.dhs.state.wi.us/hipp  
                           Phone: 1-800-446-6642 |
| **WYOMING**            | Website: http://dhss.state.wy.us/hc/hipp  
                           Phone: 307-327-7000 |

Chevron Corporation  
Summary Plan Description  
Effective January 1, 2015  
High Deductible Health Plan | Page 130
<table>
<thead>
<tr>
<th>TEXAS – Medicaid</th>
<th>WEST VIRGINIA – Medicaid</th>
</tr>
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<tbody>
<tr>
<td>Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a></td>
<td>Website: <a href="http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx">http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx</a></td>
</tr>
<tr>
<td>Phone: 1-800-440-0493</td>
<td>Phone: 1-877-598-5820, HMS Third Party Liability</td>
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<tr>
<th>UTAH – Medicaid and CHIP</th>
<th>WISCONSIN – Medicaid and CHIP</th>
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<tr>
<td>Website:</td>
<td>Website:</td>
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<tr>
<td>CHIP: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a></td>
<td>Phone: 1-800-362-3002</td>
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<tr>
<td>Phone: 1-866-435-7414</td>
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<tr>
<th>VERMONT – Medicaid</th>
<th>WYOMING – Medicaid</th>
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<td>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
<td>Website: <a href="https://wyequalitycare.acs-inc.com/">https://wyequalitycare.acs-inc.com/</a></td>
</tr>
<tr>
<td>Phone: 1-800-250-8427</td>
<td>Phone: 307-777-7531</td>
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To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

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

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

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

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

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

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

First Right of Recovery

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

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

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

Granting of an Equitable Lien by Contract

At the time the health plans pay benefits, you and/or your covered dependent grants to the health plans (as a condition of such payment) an equitable lien by contract in any property described above. This means that you grant the health plans a first right to any property (including money) that you recover as a result of the event that caused the benefits to be paid. This right to an equitable lien by contract exists without regard to the identity of the property’s source or holder at any particular time, or whether at any particular time the property exists, is segregated, or you and/or your covered dependent has any rights to it.
Creation of Constructive Trust
You and/or your covered dependent agrees that until such equitable lien by contract is completely satisfied (that is, the health plans are reimbursed in full), the holder of any such property (whether you and/or your covered dependent, you and/or your covered dependent’s attorney, an account or trust set up for you and/or your covered dependent’s benefit, an insurer, or any other holder) shall hold such property as the Omnibus Health Care Plan’s constructive trustee. The constructive trustee agrees to immediately pay over such property to or on behalf of the health plans, pursuant to their direction, to the extent necessary to satisfy the equitable lien by contract.

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

- Not to assign any rights or causes of action you may have against others (including under insurance policies) without the express written consent of the health plans.

- To take possession of any property subject to the health plans’ equitable lien by contract in your own name, place it in a segregated account within your control (at least in the amount of the equitable lien by contract), and not to alienate it or otherwise take any action so that it is not in your possession prior to the satisfaction of such equitable lien by contract.

- That if such property is not in your possession (other than in possession by or on behalf of the health plans), to immediately take whatever steps possible to regain possession or have possession transferred to or on behalf of the health plans pursuant to their direction.

- To cooperate with the health plans and take any action that may be necessary to protect the health plans’ right to recovery.

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

- The possibility that benefits paid by the health plans may be the responsibility of a third party.

- The submission of any claim or demand letter, the filing of any legal action, the request for any alternative dispute resolution process, or the commencement date of any trial or alternative dispute resolution process, regarding or related to any property that may be subject to the health plans’ rights (1) of subrogation, reimbursement and restitution, (2) to an equitable lien by contract, and (3) as beneficiary of a constructive trust.

- Any agreement that any property that may be subject to the health plans’ rights (1) of subrogation, reimbursement and restitution, (2) to an equitable lien by contract, and (3) as beneficiary of a constructive trust will be paid to or on behalf of you and/or your covered dependent (whether pursuant to resolution of a claim, legal action, alternative dispute resolution proceeding, or otherwise).

Timely notice is notice that provides the health plans with sufficient time to protect their own rights to subrogation, reimbursement and restitution; to an equitable lien by contract; and as beneficiary of a constructive trust. Notice of the commencement date of any trial or alternative dispute resolution process must be given at least 30 days in advance.
No Duty to Independently Sue or Intervene
Although the health plans’ subrogation rights include the right to file an independent legal action or alternative dispute resolution proceeding against such third party (or to intervene in one brought by or on behalf of you and/or your covered dependent), the health plans have no obligation to do so.

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

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

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

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

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

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

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

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

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

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

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

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

Conversion Coverage
If you are enrolled in an insured plan or HMO and you elect continuation coverage, you may have an option to convert your health coverage to an individual policy at the termination of your continuation coverage. Contact your insurer or HMO for additional information about any conversion rights you may have. There are no conversion rights for 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 section titled Eligible Children and Other Dependents for details on eligibility. Your domestic partner and dependent children must notify Chevron within 31 days if your domestic partnership ends. If your spouse/domestic partner and dependent children do not notify Chevron within the above time limits, they will become permanently ineligible for future continuation coverage as a result of that qualifying event.
Qualifying Events

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

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

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

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

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

Special Rule for Bankruptcy of the Employer

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

Chevron Must Give Notice of Some Events
Chevron has the responsibility to notify ADP Benefit Services, which handles Chevron’s continuation coverage administration, when any of the following occurs:

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

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

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

The following information should be included in the notice:

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

Chevron may also require you to provide documentation of a qualifying event, such as a final divorce decree, before continuation coverage is offered.
You should provide your notice to the Chevron HR Service Center at 1-888-TALK2HR (1-888-825-5247) or at 610-669-8595 if you’re outside the U.S. and can’t access the toll-free number. Your personal identification number (PIN) will be required when reporting the event by telephone. Additionally, you can mail your notice to the following address:

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

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

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

**Electing Continuation Coverage**

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

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

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

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

**Keep the Plan Informed of Address Changes**

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

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

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

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

Regular monthly COBRA payments should be mailed to:

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

Or via overnight to:

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

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

How Long Continuation Coverage Lasts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- The premium for your continuation coverage is not paid on time.

- If after electing continuation coverage, you become covered by another group health plan, unless the plan contains any exclusions or limitations with respect to any pre-existing condition you or your covered dependents may have.

- If after electing continuation coverage, you first become eligible for and enroll in Medicare Part A, Part B or both.

- You extend coverage for up to 29 months due to a qualified beneficiary’s disability and there has been a final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. In this case, continuation coverage will end on the first of the month that begins more than 30 days after the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. This will be the case only if the qualified beneficiary has been covered by continuation coverage for at least 18 months.

- Chevron no longer provides group health coverage to any of its eligible employees or eligible retirees.

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

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

- Retiree and survivor coverage.
- Continuation coverage.

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

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

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

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

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

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

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

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

- You can immediately enroll in retiree and survivor coverage after your subsidized COBRA coverage has ended, as long as you do so within 31 days of the subsidized coverage ending. You do not have to wait for an open enrollment period.

- If you die while enrolled in subsidized COBRA, your survivors can immediately enroll in retiree and survivor coverage after subsidized COBRA coverage has ended, as long as they do so within 31 days of the subsidized coverage ending.

- If you die while enrolled in another employer’s group health plan, your survivors can immediately enroll in retiree and survivor coverage after your death, as long as they do so within 31 days of your death.

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

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

Survivor coverage for your spouse/domestic partner can continue until he or she dies, cancels survivor coverage or does not make timely premium payments. Survivor coverage can continue if a surviving spouse/domestic partner remarries or enters into a new domestic partner relationship, but the new spouse/domestic partner or any other dependent(s) cannot be added to any Chevron health plan. If your spouse wishes to add his or her new spouse or other dependent to the plan, survivor coverage ends, and up to 36 months of continuation coverage becomes available.
Survivor coverage for your enrolled children can continue until the child reaches age 26 (unless incapacitated), or is no longer eligible according to the eligibility provisions for the health plans for reasons other than your death. Please see the Eligible Children and Other Dependents section for details on eligibility. If your dependent wishes to add his or her new spouse or other dependent to the plan, survivor coverage ends, and up to 36 months of continuation coverage becomes available.

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

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

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

Special Rule:

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

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

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

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

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

- The 24-month period beginning on the date on which your Military Service Leave begins;

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

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

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

How Much USERRA Continuation Coverage Costs

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

If you have any questions about the COBRA law, please contact ADP Benefit Services, 1-888-825-5247, and select option 2, then "*", then 1. If you’re outside the U.S. and can’t access the toll-free number, call or at 610-669-8595 and select option 2, then "*", then 1. Or, write to ADP Benefit Services at P.O. Box 2638, Alpharetta, GA 30023-2638.
Glossary
After-Tax Contributions
After-tax contributions are withheld from your paycheck after federal and state income taxes are withheld.

Allowable Charge
To be considered allowable, a charge must be within a range of charges billed by doctors or other providers for the same service or supply. Allowable charges may vary from one geographic area to another. Allowable charges are determined by the HDHP claims administrator (other than charges for vision care covered under the Chevron Vision Program or outpatient prescription drugs covered under the Chevron Prescription Drug Program). In the case of a covered charge from a non-network provider who is affiliated with MultiPlan, allowable charge means the discounted rate.

The discounted rates charged by providers in the PPO network aren’t subject to the allowable charge provisions of the plan.

When reviewing charges to determine if they’re covered under the plan, the plan’s claims administrator doesn’t attempt to set the amount that doctors and other providers charge for needed services, nor does the claims administrator restrict your right to go to any doctor you choose.

Ambulatory Surgical Center
A specialized facility established, equipped, operated and staffed primarily for performing surgical procedures and that meets one of the following two tests:

- It is licensed as an ambulatory surgical center by the appropriate local regulatory authority.

- Where licensing is not required, it meets all of the following requirements:
  - It is operated under the supervision of a licensed doctor (M.D. or D.O.), who is devoted full time to supervision, and it permits a surgical procedure to be performed only by a doctor who has current privileges to perform the procedure in at least one area hospital.
  - Except for cases requiring only local infiltration of anesthetics, it requires that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist to administer the anesthetic. The anesthesiologist or anesthetist remains present throughout the surgical procedure.
  - It provides at least one operating room and at least one postanesthesia recovery room.
  - It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services.
  - It has access to a blood bank or blood supplies.
  - It has trained personnel and necessary equipment to handle emergency situations.
  - It provides the full-time services of registered nurses (R.N.s) for patient care in the operating rooms and in the postanesthesia recovery room.
  - It maintains an adequate medical record for each patient.

- An ambulatory surgical center can be a stand-alone facility or part of a hospital.
Annual Deductible
The amount of certain covered charges and prescription drug charges you pay for combined network and out-of-network care and services each calendar year before the Chevron High Deductible Health Plan (HDHP) and Mental Health and Substance Abuse plans begin paying its share of those charges. Under the Chevron High Deductible Health Plan, there is one combined annual deductible for medical, prescription drugs, mental health and substance abuse services. See the Combined Deductible of this summary plan description for more information.

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

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

Birthing Center
A facility that provides a home-like setting under a controlled environment for the purpose of childbirth. These facilities legally operate under the license of a qualified hospital.

Brand-Name Drug
A prescription drug that is all of the following:

- Manufactured and marketed under a trademark or a name given by a specific drug manufacturer.
- Typically protected under patent rights.
- Commonly acknowledged by pharmacies, drug companies and drug manufacturers as a brand-name drug.

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.

Center of Excellence
UnitedHealthcare covers certain organ and tissue transplants if they are performed at a Center of Excellence. A Center of Excellence is one of several designated, well-known, highly respected hospitals throughout the country that have extensive experience with specific transplant operations.
Claims Administrator (UHC)
UnitedHealthcare is the medical claims administrator in all states (except Hawaii where the Chevron High Deductible Health Plan is not offered to employees). You can contact UnitedHealthcare at 1-800-654-0079. To get a list of UHC PPO network providers, you can log on to www.myuhc.com. To find an out-of-network provider affiliated with MultiPlan that has agreed to provide discounted rates, call 1-800-654-0079 or access the website at www.myuhc.com. Select Physicians and Facilities and then select Find Shared Savings Physicians & Facilities. To use the provider search tool, you must be a registered user and log in to the myuhc.com website. You can reach Personal Health Support at 1-800-654-0079.

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

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

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

Contracted Fees
UnitedHealthcare defines contracted fees as the amount a participating provider agrees to accept as payment in full for covered services. Contracted fees are usually lower than the provider’s normal charge.

Copayment
A flat-rate charge you pay for prescription drugs at the time your prescription is filled.

Corporation
Refers to Chevron Corporation.

Covered Charges
The plans pay only for health services that are medically necessary and appropriate for the diagnosis and treatment of sickness or injury and for certain preventive care services. Benefits paid for these services, provided by out-of-network providers, are based on allowable charges for the service or supply provided. You have to pay for services and supplies that aren’t covered under the plan. And, if you go to an out-of-network provider, you must pay any charges in excess of allowable charges. If you go to a PPO network provider for care, plan benefits are based on the discounted rates (“contracted fees”) that the provider charges, instead of on allowable charges. Covered charges can be either the contracted fees you are charged by a network provider or the allowable charges for an out-of-network service or supply.
Custodial Care
Care consisting of accommodations (including room and board and other institutional services) and services provided because of an individual’s age or other mental or physical condition (rather than care for the treatment of illness or injury). Custodial care includes assisting the individual in the activities of daily living, such as eating, walking, taking medicine, bathing and changing bed positions, which could be provided safely and reasonably by persons without professional skills or training.

Custodial care also includes health-related services that don’t seek to improve the patient’s medical condition or that are provided when the patient’s medical condition is not changing.

Doctor
The term doctor means a doctor or surgeon (M.D.), a psychiatrist (M.D.), an osteopath (D.O.), a podiatrist (D.P.M.), a dentist (D.M.D. or D.D.S.), a chiropractor (D.C.) and an ophthalmologist (O.D.).

For care to be covered under the plans, the doctor must be licensed by the proper authorities of the state in which he or she practices, and practice and treatment must be within the scope of the doctor’s license.

Durable Medical Equipment
Durable medical equipment must meet all of the following requirements:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose.
- Is generally not useful to a person in the absence of sickness or injury.
- Is appropriate for use in the home.

Experimental or Investigational Service
A medical, surgical, diagnostic, psychiatric, mental health, substance abuse or other health care service, technology, supply, treatment, procedure, drug therapy or device that is determined by the claims administrator to be any of the following:

- Not approved by the U.S. Food and Drug Administration (“FDA”) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- Subject to review and approval by any institutional review board for the proposed use or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
The HDHP claims administrator, in its judgment, may deem an Experimental or Investigational Service covered under the HDHP for treating a life-threatening sickness or condition if the HDHP claims administrator determines that the Experimental Service:

- Is proved to be safe with promising efficacy; and
- Is provided in a clinically controlled research setting; and
- Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

For the purpose of this definition, the term “life-threatening” is used to describe sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.

**Former Atlas Employee**
A person who otherwise qualifies as an eligible employee and who was employed by Atlas immediately prior to its merger with Chevron Corporation (or was employed by Chevron Northeast Upstream Corporation after the merger and on or before October 1, 2011) and who has not been terminated and rehired by Chevron or its affiliates.

**Former Caltex Employee**
A person who otherwise qualifies as an eligible employee and who was employed by Caltex immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron or its affiliates.

**Former Chevron Employee**
A person who otherwise qualifies as an eligible employee and who was employed by Chevron immediately prior to its merger with Texaco Inc. and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

**Former Texaco Employee**
A person who otherwise qualifies as an eligible employee and who was employed by Texaco Inc. immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

**Former Unocal Employee**
A person who otherwise qualifies as an eligible employee and who was employed by Unocal immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron since the merger with Unocal.
Gender Identity Disorder
A disorder characterized by the following diagnostic criteria:

- A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
- Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
- The disturbance is not concurrent with a physical intersex condition.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Generic Drug
A chemical copy of a brand-name prescription drug. Generic medications contain the same active ingredients and must be equivalent in strength and dosage to their brand-name counterparts. They are subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength and purity as their brand-name counterparts. Generally, generic drugs cost less than brand-name drugs.

Some generics look different from the brand-name version of the drug because they contain different inactive ingredients. Inactive ingredients are, for example, additives that are used to keep a tablet from crumbling, to add bulk to a tablet, or to change a tablet’s color or shape. Generic drugs typically cost 30 percent to 60 percent less than their brand-name counterparts because manufacturers of generic drugs don’t have to pay for research and development or marketing and advertising.

Health and Welfare Eligibility Service
Your health and welfare eligibility service is used to determine your eligibility for vacation, service awards, Short-Term and Long-Term Disability plans and retiree health care benefits. The following applies to an individual who is an employee on or after January 1, 2012. Different rules apply to an individual who terminated employment prior to January 1, 2012.

Health and welfare eligibility service is generally the period of time you’re employed by Chevron or by any other member of the Chevron affiliated group, and may include periods when you’re not an eligible employee for U.S. pay and benefits.

Health and welfare eligibility service includes all the time you are on an approved Disability Leave for which you are receiving benefits under the Chevron Long-Term Disability Plan. Under special rules, it may also include the time you are on certain other approved leaves of absence. Special rules apply if you do not timely return to active work with a participating company or if you terminate your employment while on an approved leave of absence. Health and welfare eligibility service may also include the time you have been providing services as a “leased employee” on or after July 1, 2002 to a member of the Chevron affiliated group (at the time the services are performed) and you become an employee after providing service as a leased employee, as determined by Chevron in its sole discretion. If you believe one of these special rules apply to you, contact the HR Service Center for further information.

If you leave Chevron after July 1, 2002, and are rehired within 365 days, your service will include the time you were away. If you’re gone longer than 365 days and you haven’t had a permanent service break as a result of your absence, your service before you left will be added to your service after you’re rehired. If you left Chevron and were rehired, your service before you left will be added to your service after you’re rehired unless you incurred a Permanent Service Break. If you have service with an acquired company prior to the date of the acquisition of that company by Chevron, special rules may apply — contact the HRSC for more information.
Note on grandfathering rules: The definition of health and welfare service has changed over time, and sometimes it has changed to include additional service that was not previously included. This will not change whether you are subject to a grandfather rule in effect prior to the change. This is because whether an employee meets the conditions to have a grandfather rule apply is determined under the rules in place as of the time the grandfather rule was effective.

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

Home Health Care Agency
A home health care agency provides services such as part-time or intermittent skilled nursing care, teaching and rehabilitation services. It also may provide rehabilitation equipment, based on a treatment plan prescribed by the patient’s doctor. The agency must be certified by Medicare and participate in the federal Medicare program in order for its charges to be covered under the plan.

Hospice
Hospices offer an alternative to hospital care for treating terminally ill patients and counseling their families. They are licensed programs or facilities designed to care for terminally ill patients with life expectancies of less than six months. Hospice care can be provided on an inpatient basis or in the patient’s home.

Hospital
A hospital must meet one of the following requirements:

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

- A free-standing rehabilitative facility that meets all of the following criteria:
  - Has a provider agreement, as required by Medicare.
  - Serves an inpatient population, with at least 75 percent of patients needing intensive rehabilitative services for the treatment of a stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of the femur, brain injury, polyarthritis, neurological disorders and burns.
  - Has a preadmission screening procedure to determine whether the patient would benefit from an intensive inpatient hospital program.
  - Ensures that patients receive close medical supervision and furnishes rehabilitation nursing, physical therapy and occupational therapy by qualified personnel.
  - Has a director of rehabilitation who is a doctor.
  - Establishes a plan of treatment, for every patient that is reviewed, as needed by a doctor who consults with other qualified personnel.
  - Uses a coordinated team approach to rehabilitate each patient.
The term *hospital* doesn’t include any of the following facilities:

- Any institution used primarily as a rest or nursing facility.
- Any facility solely for use by the aged or the chronically ill or alcoholics.
- Any facility providing primarily educational or custodial care.

**Incapacitated Child**

An incapacitated child is a dependent child who is:

- Incapable of self-sustaining employment by reason of mental retardation or a mental or physical disability (proof of which must be medically certified by a physician).
- Dependent on you, your spouse/domestic partner or your surviving spouse/domestic partner who is covered under the plan, for more than one-half of his or her financial support.
- Your or your spouse/domestic partner’s qualifying child under section 152 of the Internal Revenue Code. This means that during the calendar year the individual: 1) is your child, brother, sister, stepbrother, stepsister or a descendent of such person 2) lives with you for more than one-half the year and 3) does not provide over one-half of his or her own support.

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

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

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

**Inpatient Care**

Care that’s provided while an individual is confined as a bed patient in a hospital.

**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.
Maintenance Medication
Medication taken over an extended period of time (90 days or more) for the treatment of a chronic condition, such as diabetes, arthritis, ulcers, high blood pressure or heart conditions.

Managed Prior Authorization
The Express Scripts program that requires certain drugs to be approved by Express Scripts before the drug is dispensed in order for the drug to qualify as a covered charge.

Medical Channel Management
The Express Scripts program aimed at identifying opportunities for shifting drug utilization from the medical channel to the pharmacy channel with respect to specialty drugs.

Medically Necessary
This term generally refers to health care services or supplies that are determined by the claims administrator, in its sole discretion, to be medically appropriate and that are all of the following:

- Necessary to meet the basic health needs of the plan member or covered dependent.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the health care service or supply.
- Consistent in type, frequency and duration with scientifically-based guidelines of national medical, research or health care coverage organizations or governmental agencies that are accepted by the claims administrator as to the type, frequency or duration of treatment.
- Consistent with the diagnosis of the condition.
- Required for reasons other than for the comfort or convenience of the patient, the patient’s family, the doctor or other provider.
- Demonstrated through prevailing peer-reviewed medical literature to be either of the following:
  — Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed.
  — Safe, with promising efficacy for treating a life-threatening sickness or condition, provided in a clinically controlled research setting and using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

For purposes of this definition, the term life-threatening is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment. The fact that a doctor has performed, prescribed, ordered, recommended or approved a procedure or treatment, or the fact that it may be the only treatment for a particular illness, injury or pregnancy, doesn’t mean that it’s medically necessary and appropriate as defined here.

Multi-Source Drug
A medication that is available from multiple manufacturers and can include Brand-Name Drugs and Generic Drugs depending on patent status.
Network Pharmacy
Express Scripts, the administrator of the Prescription Drug Program’s retail pharmacy program, has negotiated a discount agreement with more than 60,000 pharmacies across the U.S. These pharmacies make up a network that includes pharmacy chains, pharmacies at discount stores, pharmacies at local and national grocery chains and many independent pharmacies. For participating pharmacies near you, visit www.Express-Scripts.com or call Express Scripts Member Services at 1-800-987-8368.

Network Price
A discounted price charged for a prescription when a network pharmacy is used.

Nonpreferred Brand-Name Drugs
Drugs that are covered by the Prescription Drug Program, which receive a lower level of reimbursement compared with preferred brand-name drugs. These drugs are not on Express Scripts’ list of preferred brand-name drugs.

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

Nurse-Midwife
A registered nurse (R.N.) who has passed the American College of Nurse-Midwives’ national exam for certification.

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

Out-of-Pocket Maximum
Your HDHP Out-of-Pocket Maximum is the most you will have to pay out of pocket for a year for covered services. When you reach this amount, the HDHP begins to pay 100 percent of the allowed amount for covered services. Your annual deductible and coinsurance, you pay generally apply toward the out-of-pocket maximum. In addition any amounts incurred during a year which count toward your out-of-pocket maximum under the Chevron Corporation Prescription Drug Program Supplement Plan F to the Omnibus Plan and/or the Chevron Corporation Mental Health/Substance Abuse Plan Supplement Plan H to the Omnibus Plan, if any, will be counted toward your out-of-pocket maximum under this HDHP

Outpatient Care
Care provided without an overnight stay in a hospital.

Outpatient Prescription Drugs
Drugs that are dispensed by a retail or home delivery pharmacy (excluding drugs dispensed at hospitals, doctors’ offices or skilled nursing facilities).

Outpatient Treatment
Treatment or care provided without an overnight stay in a medical facility.
Payroll
The system used by Chevron to withhold employment taxes and pay its common-law employees. The term doesn’t include any system to pay workers whom Chevron doesn’t consider to be common-law employees and for whom employment taxes aren’t withheld — for example, workers Chevron regards as independent contractors or common-law employees of independent contractors.

Permanent Service Break (for health and welfare eligibility service)
You will not have a permanent service break if you leave Chevron with more than five years of health and welfare eligibility service. You will, however, have a permanent service break if you leave Chevron before you have five years of health and welfare eligibility service and you’re not rehired within five years. If you left employment with Chevron before January 1, 2012, the applicable rules at the time of your termination will apply to whether you had a permanent service break.

Preferred Brand-Name Drugs
Drugs that are covered by the Prescription Drug Program and receive a higher level of reimbursement compared with nonpreferred drugs. The list of preferred brand-name drugs (sometimes called a formulary list) includes commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings. Preferred brand-name drugs receive a higher level of reimbursement compared with nonpreferred brand-name drugs. For updated formulary information, visit www.Express-Scripts.com or call Express Scripts Member Services at 1-800-987-8368.

Prescription Drug Program ID Card
When you enroll in the Chevron High Deductible Health Plan, you’ll receive a special prescription ID card to use every time you have a prescription filled at a network pharmacy. The card includes your Express Scripts member ID number, which is different from your medical plan ID number.

Primary Payer
The plan that pays benefits first.

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

Prosthetic Devices
Devices that replace a limb or body part. The device must be ordered or provided by or under the direction of a doctor. Examples of prosthetic devices include:

- Artificial limbs.
- Artificial eyes.
- Breast prosthesis, as required by the Women’s Health and Cancer Rights Act of 1998.
**Provider**
A hospital, medical or health care facility, doctor, dentist or other health professional, licensed where required, performing within the scope of that license.

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

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

**Regular Work Schedule**
A continually recurring pattern of scheduled work that’s established and changed by Chevron as necessary to meet operating needs.

**Residential Treatment Program**
A program of treatment given in a facility that provides 24-hour residential care to patients who don’t require acute care services or 24-hour nursing care. The program provides structured mental health or substance abuse treatment that includes medical supervision by a doctor and is staffed by a multidisciplinary team, which may include doctors, psychologists, social workers, registered nurses (R.N.s) and other health care professionals. The program must be licensed, certified or approved by the state in which the program operates.

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

**Secondary Payer**
The plan that pays benefits second.

**Single-Source Brand-Name Drugs**
A Brand-Name Drug that doesn’t have a generic equivalent and is only available from one manufacturer or source, typically the original company.
Skilled Nursing Facility
An institution that charges a fee and meets all of the following requirements:

- It furnishes room and board and nursing services for medical care.
- It has one or more licensed nurses on duty at all times, working under the constant supervision of a registered nurse (R.N.) or licensed doctor.
- It has available, at all times, the services of a licensed doctor.
- It complies with all legal requirements applicable to the operation of such an institution.
- It maintains medical records on all its patients at all times.
- It’s approved under Medicare.

The term *skilled nursing facility* doesn’t include any of the following:

- An institution used primarily as a rest facility.
- Facilities for the aged, drug addicts or alcoholics.
- Facilities provided primarily for custodial or educational care.

Specialty Drug
A prescription drug that Express Scripts has designated as a Specialty Drug. In general, Specialty Drugs are high-cost drugs that may be used to treat complex or rare medical conditions. Specialty Drugs are generally biotechnological in nature and may have special shipping, storage or handling requirements. Specialty Drugs often require injection or other non-oral methods of administration.

Some of the disease categories for which certain prescription drugs are currently designated as Specialty Drugs by Express Scripts’s include cancer, cystic fibrosis, Gaucher disease, growth hormone deficiency, hemophilia, immune deficiency, Hepatitis C, infertility, multiple sclerosis, rheumatoid arthritis, and RSV prophylaxis. Express Scripts may add or delete drugs from the Specialty category as new treatments become available.

For information on whether a particular drug is a Specialty Drug, or whether it is subject to the home delivery requirement for maintenance Specialty Drug refills, contact Express Scripts at 1-800-987-8368.

Specialty Pharmacy
Express Scripts Specialty Pharmacy, Accredo. A Specialty Drug must be ordered through the Specialty Pharmacy in order to be a covered charge.

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

UnitedHealthcare is the claims administrator for the Chevron High Deductible Health Plan in all states (except Hawaii where the plan is not available to employees). UHC reviews, approves (or denies) and processes all claims other than those for outpatient prescription drugs, mental health and substance abuse services and vision care. UHC also manages the PPO network of providers. In addition, their staff informs plan members as to which charges are covered and which aren’t under the plan. If you have a question about a claim or if you need to speak with a customer service representative, call UnitedHealthcare at 1-800-654-0079. For a list of UHC PPO network providers, you can log on to the website at www.myuhc.com.

As part of your benefit, UHC also offers a team of registered nurses — the Nurse Advisor Team — dedicated solely to Chevron. You can call a nurse advisor with questions or concerns for health matters big and small. A nurse advisor can help you with condition management (for example diabetes or asthma), understanding an illness, an upcoming hospitalization, major surgery or treatment options. They can also help you understand and follow your doctor’s treatment plan and self-care suggestions, provide you with educational materials and individualized support, find doctors or other health care professionals in the network as well as connect you with communication resources. You can contact a nurse 24 hours a day, seven days a week at 1-800-654-0079.

UHC’s Personal Health Support, a pre-service review team administers the plan’s Health Care Review procedures. The Personal Health Support staff reviews proposed hospitalization and other specified procedures to confirm they’re medically necessary for the condition being treated. Approval is required before full plan benefits can be paid for some kinds of care. You can call Personal Health Support at 1-800-654-0079 between 7 a.m. and 5 p.m. Pacific time, Monday through Friday.

Unproven Services

Health Services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer reviewed medical literature.

If you have a life-threatening sickness or condition (one that is more likely than not to cause death within one year of the date of the request for treatment), the claims administrator may, at its discretion, consider an otherwise Unproven Service to be a covered service for that sickness or condition. Prior to such a consideration, claims administrator must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that sickness or condition.

VSP (Vision Service Plan) Vision Care

VSP is the insurer for the vision benefits you receive through the Chevron Vision Program and also the Vision Plus Program. VSP manages the vision preferred provider organization and processes claims filed by you or your provider. VSP can be reached by telephone at 1-800-877-7195 Monday through Friday from 5 a.m. to 8 p.m. Pacific time, Saturday from 7 a.m. to 8 p.m. Pacific time and on Sunday 7 a.m. to 7 p.m. Pacific time. Or you can access the VSP’s website at www.vsp.com/go/chevron.
Company Contributions to Medical Coverage
Supplement to the Summary Plan Description (SPD)
Effective January 1, 2014

This supplement generally describes the Chevron Corporation Policy regarding its contribution to the cost of medical coverages that are eligible for a Chevron company contribution. This is not a plan text, a summary plan description or a summary of material modification because the amount of the company contribution and how it is determined is not itself part of a medical plan. Nevertheless, if it should be determined to be part of a medical plan, the Supplement, as modified herein, shall constitute the applicable plan provision and summary plan description. There are no vested rights with respect to Chevron medical plans or any company contributions toward the cost of such medical plans. Rather, Chevron Corporation reserves all rights for any reason and at any time to amend, change or terminate these plans or to change or eliminate the company contribution toward the cost of such plans. Such amendments, changes, terminations or eliminations may be applicable without regard to whether someone previously terminated employment with Chevron or was previously subject to a grandfathering provision. Some benefit plans and policies described in the Supplement may be subject to collective bargaining and, therefore, may not apply to union-represented employees.
Table of Contents

Key Contacts ................................................................................................................................................ 4
Company Contributions to Employee Medical Coverage ................................................................. 5
Company Contributions to Retiree Medical Coverage .................................................................... 6
Examples .................................................................................................................................................... 10
About Health and Welfare Eligibility Service ....................................................................................... 13
Glossary ..................................................................................................................................................... 14
## Key Contacts

**Benefits Connection Website**  
The Benefits Connection website provides information about the company contribution to medical coverage.

- **hr2.chevron.com.** Click the **Benefits Connection** link near the top of the page to get started.
- Go to the **Health and Welfare** tab on the top navigation for the current company contribution to your medical coverage.
- Go to the **Retirement Plan** tab on the top navigation for:
  - The date you may be eligible for retiree medical coverage.
  - To access a calculator that will help you project the future percentage of the company contribution to retiree medical coverage.

**HR Service Center**

- 1-888-825-5247 (Inside the U.S.)
- 610-669-8595 (Outside the U.S.)
- 6 a.m. to 5 p.m., Pacific time (8 a.m. to 7 p.m., Central time)
- Monday through Friday, except on holidays.

**Read Summary Plan Descriptions Online**  
You can find summary plan descriptions, general benefit summaries and information about the medical plans Chevron offers to active employees and retirees on the U.S. Benefits website.

- **hr2.chevron.com**
Company Contributions to Employee Medical Coverage

Chevron Corporation determines the total cost of the various medical plans it offers. In general, Chevron Corporation has an “80/20” cost-sharing approach with respect to such total cost. This means that the company pays approximately 80 percent of that cost, and you pay the remaining 20 percent. With this approach, Chevron typically pays 80 percent of the premium for your health care plan or a set maximum company contribution, whichever is less. The maximum company contribution is based on 80 percent of the total premium of the Medical PPO Option 2. If your plan costs less, Chevron will pay 80 percent of the cost of your plan. If your plan costs more, Chevron will pay up to the maximum contribution.

Example
Here’s an example based on family coverage:

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>2014 Monthly Cost for Family Coverage</th>
<th>Company Contribution Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Premium</td>
<td>Company Contribution</td>
</tr>
<tr>
<td>Medical PPO Option 2</td>
<td>$1,585</td>
<td>$1,269</td>
</tr>
<tr>
<td>Medical PPO Option 1</td>
<td>$1,709</td>
<td>$1,269</td>
</tr>
<tr>
<td>Global Choice Plan</td>
<td>$1,241</td>
<td>$993</td>
</tr>
</tbody>
</table>

Medical PPO Option 2 has a total premium of $1,585. Eighty percent of that total premium is the maximum company contribution for family coverage ($1,269).

As you can see, the Medical PPO Option 1 premium is more than Medical PPO Option 2. Therefore, the company contribution equals the set maximum of $1,269.

Based on 80 percent of the total premium for Medical PPO Option 2, here are the maximum monthly contributions for all coverage levels:

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>2014 Maximum Monthly Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>You Only</td>
<td>$470</td>
</tr>
<tr>
<td>You and One Adult</td>
<td>$940</td>
</tr>
<tr>
<td>You and Child(ren)</td>
<td>$799</td>
</tr>
<tr>
<td>You and Family</td>
<td>$1,269</td>
</tr>
</tbody>
</table>
Company Contributions to Retiree Medical Coverage

If you’re an eligible retiree, the company currently continues to share the cost of your medical coverage. In general, to be eligible for retiree medical coverage, you must meet both of the following requirements:

- You are at least age 50 with 10 years or more of health and welfare eligibility service.
- At least five years of your total health and welfare eligibility service occurred since your last rehire date.

If you are a retiree not eligible for Medicare, your starting company contribution to retiree medical coverage will be based on the maximum active employee company contribution amount in the calendar year you retire. This amount will be prorated based on the applicable percentage corresponding to your points, as described below. Please note that the cost of retiree medical coverage is greater than the maximum company contribution, so even if you have enough points to receive 100 percent of the company contribution, you will still have to pay for coverage.

The company contribution amount toward retiree medical coverage is different if you are Medicare-eligible when you retire or if you become Medicare-eligible as a retiree. All Medicare-eligible retirees receive the same company contribution amount, regardless of year of retirement. Your actual company contribution amount is prorated based on the applicable percentage corresponding to your points at retirement, as described below.

The base company contribution is determined by the calendar year you separate from the company. If you are subsequently rehired, the company contribution determination will continue to be based on your first separation date. Chevron limits future increases to the applicable company contribution to no more than 4 percent each year, applied to the starting or existing company contribution amount.

Company Contribution Amount and Proration of Company Contribution Amount

As indicated above, your applicable starting company contribution amount may be prorated based upon your “points” at retirement. Points represent the sum of your age plus years of health and welfare eligibility service when you leave the company. Each point level corresponds to a percentage, which represents the percentage of the company contribution for which you are eligible. In general, the longer you work, the more points you can accumulate, resulting in a higher percentage and therefore a higher company contribution amount toward retiree medical coverage.

In general, if you retired on or after July 1, 2002, one of the following point scales is used to determine the amount of company contribution you receive:

- The 90-point scale applies to retirees eligible for retiree medical who terminate or retire on or after January 1, 2005, unless a grandfather rule applies to you.

- The 80-point scale applies to retirees eligible for retiree medical who retired between July 1, 2002, and December 31, 2004, and to employees who were age 50 or over with at least 10 years of service on December 31, 2004 (as determined under the applicable rules in effect on December 31, 2004), and who retire after that date, unless a grandfather rule applies to you.
The following chart indicates the company contribution under the 80-point scale and the 90-point scale:

<table>
<thead>
<tr>
<th>Age Plus Years of Health and Welfare Service Points</th>
<th>Company Contribution Under the:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80-Point Scale</td>
</tr>
<tr>
<td>60</td>
<td>50%</td>
</tr>
<tr>
<td>61</td>
<td>52.5%</td>
</tr>
<tr>
<td>62</td>
<td>55%</td>
</tr>
<tr>
<td>63</td>
<td>57.5%</td>
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<tr>
<td>64</td>
<td>60%</td>
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<tr>
<td>65</td>
<td>62.5%</td>
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<td>66</td>
<td>65%</td>
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<tr>
<td>67</td>
<td>67.5%</td>
</tr>
<tr>
<td>68</td>
<td>70%</td>
</tr>
<tr>
<td>69</td>
<td>72.5%</td>
</tr>
<tr>
<td>70</td>
<td>75%</td>
</tr>
<tr>
<td>71</td>
<td>77.5%</td>
</tr>
<tr>
<td>72</td>
<td>80%</td>
</tr>
<tr>
<td>73</td>
<td>82.5%</td>
</tr>
<tr>
<td>74</td>
<td>85%</td>
</tr>
<tr>
<td>75</td>
<td>87.5%</td>
</tr>
<tr>
<td>76</td>
<td>90%</td>
</tr>
<tr>
<td>77</td>
<td>92.5%</td>
</tr>
<tr>
<td>78</td>
<td>95%</td>
</tr>
<tr>
<td>79</td>
<td>97.5%</td>
</tr>
<tr>
<td>80</td>
<td>100%</td>
</tr>
<tr>
<td>81</td>
<td></td>
</tr>
<tr>
<td>82</td>
<td></td>
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<tr>
<td>83</td>
<td></td>
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<td>84</td>
<td></td>
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<td>85</td>
<td></td>
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<td>86</td>
<td></td>
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<td>87</td>
<td></td>
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<tr>
<td>88</td>
<td></td>
</tr>
<tr>
<td>89</td>
<td></td>
</tr>
<tr>
<td>90</td>
<td></td>
</tr>
</tbody>
</table>
Grandfather Rules

There are some exceptions to the company contribution amount you may receive. Some retirees are eligible for retiree health care coverage at 100 percent of the maximum company contribution under the rules of former Chevron, former Texaco or former Unocal plans. In these cases, retirees have been protected, or grandfathered, under old or alternate rules. These grandfather rules are described below:

- A former Chevron employee is a person who otherwise qualifies as an eligible employee and who was employed by Chevron immediately prior to its merger with Texaco Inc. and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

- A former Texaco employee is a person who otherwise qualifies as an eligible employee and who was employed by Texaco Inc. immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

- A former Unocal employee is a person who otherwise qualifies as an eligible employee, who was employed by Unocal immediately prior to its merger with Chevron Corporation, and who has not been terminated and rehired by Chevron since the merger with Unocal.

- Whether an employee meets the conditions to have a grandfather rule (including the 80-point scale) apply is determined under the rules in place as of the time the grandfather rule became effective. For example, a change to the health and welfare eligibility service, effective January 1, 2012, does not affect the amount of service the employee had on December 31, 2004 for purposes of whether the 80-point scale applies. (However, if the 80-point scale applies to an employee without regard to the additional service, the additional service would count toward the employee’s points on the 80-point scale).

If you’re a former Chevron, or former Caltex or former Texaco employee and meet one of the following grandfathering requirements, you receive 100 percent of the company’s contribution toward your medical coverage when you retire, subject to the 4 percent limit on future increases to the company contribution:

- You’re a former Chevron or former Caltex employee employed by the company on June 30, 2002, and you meet all of the following criteria:
  
  — You must have had at least 20 years of continuous service or 65 points (age plus years of continuous service) on June 30, 2002, (as determined under the applicable rules in effect on June 30, 2002).

  — You have at least 25 years of health and welfare eligibility service or at least 75 points (age plus years of health and welfare eligibility service) when you retire.

  — You have not been rehired since July 1, 2002.

- You’re a former Texaco employee employed by the company on June 30, 2002, and on October 1, 1999, you were a Texaco employee who was age 45 or older and you retire at age 55 or older with at least 10 years of health and welfare eligibility service.
If you’re a former Unocal employee employed by the company on June 30, 2006, you may be eligible for a company contribution percentage based on the grandfathered Unocal transition scale. If you retire on or after July 1, 2006, at age 55 or older with 10 or more years of health and welfare eligibility service, and you meet the age and service requirements by December 31, 2007, (as determined under the applicable rules in effect on December 31, 2007), you will be eligible for the greater (that is, the greater company contribution percentage) of the Chevron 90-point scale or the grandfathered Unocal transition scale shown below:

Grandfathered Unocal Transition Scale

<table>
<thead>
<tr>
<th>Years of Service After Age 35</th>
<th>Company Contribution Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>50.0%</td>
</tr>
<tr>
<td>11</td>
<td>55.0%</td>
</tr>
<tr>
<td>12</td>
<td>60.0%</td>
</tr>
<tr>
<td>13</td>
<td>65.0%</td>
</tr>
<tr>
<td>14</td>
<td>70.0%</td>
</tr>
<tr>
<td>15</td>
<td>75.0%</td>
</tr>
<tr>
<td>16</td>
<td>80.0%</td>
</tr>
<tr>
<td>17</td>
<td>85.0%</td>
</tr>
<tr>
<td>18</td>
<td>90.0%</td>
</tr>
<tr>
<td>19</td>
<td>95.0%</td>
</tr>
<tr>
<td>20</td>
<td>100.0%</td>
</tr>
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Rehired Retirees Who Subsequently Retire a Second Time

If you retire from Chevron having met eligibility requirements for retiree medical coverage under any applicable eligibility rule at the time you retire, and you subsequently are rehired and then retire again, you are eligible for the better of the corresponding company contribution to retiree medical coverage based on the date you first retired (as in effect at the time of your second retirement) and any subsequent eligibility for retiree medical for which you qualify, taking into account your second period of employment.
Examples: How Points and Company Contributions Amounts Are Determined with Respect to Retiree Medical Coverage

Here are some examples to help you understand how points and company contribution amounts are determined. These examples assume that the individuals qualify for retiree medical coverage. They are estimates in which the age, service and points are rounded for purposes of the illustration only. Actual age plus years of service point calculations performed by the HR Service Center upon an employee’s retirement extend to four decimal points, and service is currently counted until the end of the month in which the employee terminates Chevron employment.

Chris, a Chevron employee retiring under the new 90-point scale
Chris is 36 years old with seven years of service.

Chris’ points
Chris has 43 age plus years of service points (36 years old plus seven years of service). Chris is not eligible for retiree medical coverage because he is not 50 years old with 10 years of service. When Chris turns 50, he will have 71 age plus years of service points, making him eligible for 61 percent of the maximum applicable company contribution for retiree medical coverage. Because Chris is not eligible for any grandfathering, he will need 90 points to qualify for 100 percent of the applicable company contribution for retiree medical coverage.

Chris’ eligibility for the 100 percent company contribution
When Chris has 90 age plus years of service points he will be eligible for 100 percent of the applicable company contribution for retiree medical coverage.

Pat, a Chevron employee grandfathered under the 80-point scale
Pat is grandfathered under the grandfathering provision — age 50 or older with 10 years of service on December 31, 2004. Pat is 56 years old with 16 years of service.

Pat’s points
Pat has 72 age plus years of service points (56 years old plus 16 years of service), making her eligible for 80 percent of the applicable company contribution for retiree medical coverage.

Pat’s eligibility for the 100 percent company contribution
Pat will be eligible for 100 percent of the applicable company contribution for retiree medical coverage when she earns 80 age plus years of service points.
Robert, a former Chevron employee
Robert is a former Chevron employee, grandfathered under former Chevron rules. Robert is 58 years old with 28 years of service.

Robert’s points
Robert has 86 age plus years of service points. Robert is grandfathered under the former Chevron rule because he had at least 20 years of continuous service or 65 points on June 30, 2002, and when he retires he will have at least 25 years of health and eligibility service or at least 75 points.

Robert’s eligibility for 100 percent of the applicable company contribution
Because he was eligible for the grandfather rule, Robert currently is eligible for 100 percent of the applicable company contribution.

Maria, a former Texaco employee
Maria is a former Texaco employee, grandfathered under the former Texaco rules, who was age 45 or older on October 1, 1999. Maria is 60 years old with 16 years of service.

Maria’s points
Maria has 76 points. However, Maria should not refer to the 80-point scale to determine her percentage of company contribution since she already meets the former Texaco grandfather rules as noted below.

Maria’s eligibility for 100 percent of the applicable company contribution
Because she was age 45 or older as of October 1, 1999, and will be retiring at age 55 or older with 10 years of health and welfare eligibility service, Maria is currently eligible to retire with 100 percent of the applicable company contribution.
Terry, a former Unocal employee
Terry is a former Unocal employee who wants to retire and who is 59 years old with 26 years of service. He will have 85 points (59 + 26) under the Chevron 90-point scale — equivalent to a company contribution percentage of 85 percent of the starting maximum company contribution amount for this year. However, Terry meets the requirements of the grandfathered Unocal transition scale (the Unocal transition scale gives him 100 percent of the applicable company contribution).

Terry’s eligibility for 100 percent of the applicable company contribution
Terry meets the age and service requirement for eligibility under the grandfathered Unocal transition scale because he had 20-plus years of service after age 35 on December 31, 2007. According to the Unocal transition scale, this service is equivalent to 100 percent of the applicable company contribution. The greater amount (100 percent) will be applied against the total cost of retiree coverage.

Mike, a former Unocal employee
Mike is a former Unocal employee who wants to retire. As of December 31, 2007, he was age 54 with 20 years of service. He does not meet the eligibility requirements for the grandfathered Unocal transition scale because he did not satisfy the age and service requirements by December 31, 2007. Therefore, when he retires, he will be eligible for the Chevron 90-point scale.

Mike’s eligibility for 100 percent of the applicable company contribution
Mike will be eligible for 100 percent of the applicable company contribution for retiree medical coverage when he earns 90 age plus years of service points.
About Health and Welfare Eligibility Service

Definition of Health and Welfare Eligibility Service
Your health and welfare eligibility service is used to determine your eligibility for vacation, service awards, Short-Term and Long-Term Disability plans and retiree health care benefits. The following applies to an individual who is an employee on or after January 1, 2012. Different rules apply to an individual who terminated employment prior to January 1, 2012.

Health and welfare eligibility service is generally the period of time you’re employed by Chevron or by any other member of the Chevron affiliated group, and may include periods when you’re not an eligible employee for U.S. pay and benefits.

Health and welfare eligibility service includes all the time you are on an approved Disability Leave for which you are receiving benefits under the Chevron Long-Term Disability Plan. Under special rules, it may also include the time you are on certain other approved leaves of absence. Special rules apply if you do not timely return to active work with a participating company or if you terminate your employment while on an approved leave of absence. Health and welfare eligibility service may also include the time you have been providing services as a “leased employee” on or after July 1, 2002 to a member of the Chevron affiliated group (at the time the services are performed) and you become an employee after providing service as a leased employee, as determined by Chevron Corporation in its sole discretion. If you believe one of these special rules apply to you, contact the HR Service Center for further information.

If you leave Chevron after July 1, 2002, and are rehired within 365 days, your service will include the time you were away. If you’re gone longer than 365 days and you haven’t had a permanent service break as a result of your absence, your service before you left will be added to your service after you’re rehired.

If you left Chevron and were rehired, your service before you left will be added to your service after you’re rehired unless you incurred a Permanent Service Break. If you have service with an acquired company prior to the date of the acquisition of that company by Chevron, special rules may apply — contact the HR Service Center for more information.

Note on grandfathering rules: The definition of health and welfare eligibility service has changed over time, and sometimes it has changed to include additional service that was not previously included. This will not change whether you are subject to a grandfather rule in effect prior to the change. This is because whether an employee meets the conditions to have a grandfather rule apply is determined under the rules in place as of the time the grandfather rule was effective.

Definition of a Permanent Service Break
You will not have a permanent service break if you leave Chevron with more than five years of health and welfare eligibility service. You will, however, have a permanent service break if you leave Chevron before you have five years of health and welfare eligibility service and you’re not rehired within five years. If you left employment with Chevron before January 1, 2012, the applicable rules at the time of your termination will apply to whether you had a permanent service break.
Glossary

**Former Atlas Employee**
A person who otherwise qualifies as an eligible employee and who was employed by Atlas immediately prior to its merger with Chevron Corporation (or was employed by Chevron Northeast Upstream Corporation after the merger and on or before October 1, 2011) and who has not been terminated and rehired by Chevron or its affiliates.

**Former Caltex Employee**
A person who otherwise qualifies as an eligible employee and who was employed by Caltex immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron or its affiliates.

**Former Chevron Employee**
A person who otherwise qualifies as an eligible employee and who was employed by Chevron immediately prior to its merger with Texaco Inc. and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

**Former Texaco Employee**
A person who otherwise qualifies as an eligible employee and who was employed by Texaco Inc. immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

**Former Unocal Employee**
A person who otherwise qualifies as an eligible employee and who was employed by Unocal immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron since the merger with Unocal.