long-term care insurance plan

summary plan description

effective january 1, 2018

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This document describes the Long-Term Care Insurance Plan as of January 1, 2018, that Chevron offers for eligible employees. This information constitutes the SPD of the Chevron Long-Term Care Insurance Plan as required by the Employee Retirement Income Security Act of 1974 (ERISA). These descriptions don't cover every provision of the plan. Many complex concepts have been simplified or omitted to present more understandable plan descriptions. If these 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.

Furthermore, you will receive a Certificate of Coverage from Genworth Life within 30 days after you are approved for enrollment in this plan. In the event of a conflict between the terms in this document and the Certificate of Coverage, the Certificate of Coverage governs.

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**.

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benefit contact information

Chevron Benefits HR2 Website

Why access this website

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

Website information

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

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

Why contact this administrator

- Change your address with Chevron.
- Report a death.
- Request an *Intent to Retire* package.
- Request a printed copy of summary plan descriptions (SPD).

Phone information

- 1-888-825-5247

Website information

- **Benefits Connection** website for personal information and to conduct certain transactions, such as changing your address, updating your beneficiaries, viewing your current enrollments and costs, enrolling in Chevron benefits, making benefit changes or open enrollment elections.
- As an employee, go to **hr2.chevron.com** and click the **Benefits Connection** link.
- After you leave Chevron, go to **hr2.chevron.com/retiree** and click the **Benefits Connection** link.
- If you have access to a Chevron workstation connected to the GIL computing network, you can use the automatic login feature; you don't need a password to access the Benefits Connection website.
- If you don't have access to a Chevron workstation connected to the GIL computing network, you will need to enter your Benefits Connection User ID and Passcode; automatic login is not available. Follow the instructions on the Benefits Connection login screen if you need to register to use the website or if you don't remember your User ID and Passcode. Please note that the PIN used when you call the HR Service Center is *different* from the Passcode used to access the Benefits Connection website.

Genworth Life Insurance Company (Genworth Life)

Why contact this administrator

- Request an enrollment kit for yourself or your eligible family members.
- Enroll in or change your coverage.
- Submit a claim.

Phone information

- 1-800-416-3624

Website information

- Go to **genworth.com/chevron**.

Summary Plan Descriptions

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

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

overview

The Long-Term Care Insurance Plan is designed to provide asset protection in the event you or a family member can no longer perform simple everyday activities you take for granted, such as getting out of bed, eating or bathing. Although most people associate long-term care with their later years, it's important to know that the need for long-term care can happen at any time and at any age due to an unexpected illness or accident.

The Long-Term Care Insurance Plan is administered by Genworth Life Insurance Company (Genworth Life), who insures the benefits' and offers:

- **Group rates:** This insured-pay-all plan is available at group rates. Premiums cannot increase just because you get older or use your benefits.
- **Flexibility:** You can select the level of monthly benefit you receive, as well as the duration of the benefit.
- **Available to family members:** In addition to protecting yourself, coverage is also available for your eligible family members.
- **Freedom of choice:** When you're eligible for benefits, you make the decisions about where to receive care and which providers to use.

eligibility

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

Eligible Employees

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

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

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

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

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

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

Chevron Human Resources Service Center
P.O. Box 18012
Norfolk, VA 23501

1-888-825-5247

Eligible Spouse

If you're legally married under the law of a state or other jurisdiction where the marriage took place, your spouse can enroll for coverage.

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 by calling the HR Service Center. The original of the affidavit 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.sos.ca.gov/registries/domestic-partners-registry/**.

3. You live in another state (such as Colorado, District of Columbia, Hawaii, Illinois, Maine, Nevada, New Jersey, Oregon, Washington, Wisconsin 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.

Other Eligible Family Members

In addition to your spouse/domestic partner, eligible family members include your:

- Children over age 18 (where permissible by state regulations).
- Parents.
- Parents-in-law.
- Grandparents.
- Grandparents-in-law.
- Siblings.
- Siblings-in-law.

Your eligible family members can enroll in the plan at any time, even if you decide not to enroll.

NOTE: Individuals that live in Vermont are not able to participate in the Long-Term Care Insurance plan. This plan has not been approved by the state of Vermont.

participation

How to Enroll

You need a Genworth Life enrollment kit to start the enrollment process. You must request a kit as one will not be automatically sent to you. To request a kit for yourself or your eligible family members, you can do either of the following:

- Call the HR Service Center at 1-888-825-5247.
- Go to **www.genworth.com/chevron**.

You and your family members enroll by completing an enrollment form and mailing it to Genworth Life.

Proof of Good Health

Proof of good health (also called *full medical underwriting*) is not required if you enroll within 90 days of your hire date and are:

- A full-time employee working at least 40 hours per week.
- Under age 66.

Proof of good health is required if you:

- Enroll more than 90 days after your hire date.
- Are an active, full-time employee over age 66 (even if you enroll within 90 days of your hire date).
- Are a benefit-eligible part-time employee.
- Are enrolling as a spouse/domestic partner, retiree or extended family member of an employee.

When Participation Begins

Generally, Long-Term Care Insurance Plan coverage for you and your family members is effective on the first of the month following the date Genworth Life approves your enrollment forms. If you are not at work on your scheduled effective date, your coverage will be effective the first day of your regularly scheduled payroll billing period in which you are actively at work, and have been actively at work for the prior 30 calendar day period.

how much you pay for coverage

You pay the full premium for the Long-Term Care Insurance Plan. Premiums are based on your coverage selections and your age. The younger you are when you enroll, the lower your premium. Once you are enrolled, premiums under this plan do not increase because you get older, your health changes, or you receive benefits from the plan.

Genworth Life has a limited right to change premiums due in the future. This can happen either on a group policy or class basis, but only if Genworth Life changes the premiums for all similar certificates issued under the group policy in the same state as your coverage.

Your premium is based on your age when you apply for coverage. Premiums are based on the coverage options, monthly benefit, total lifetime benefit, benefit increase options, and whether you have selected the optional nonforfeiture feature.

Premiums

The premiums for Long-Term Care Insurance are paid directly to Genworth Life. You can choose from any of the following payment options:

- Monthly bank account deduction.
- Quarterly direct bill.
- Semiannual direct bill.
- Annual direct bill.

Premium Waiver

Once you have been authorized to receive benefits and have fulfilled the 90-day waiting period, Genworth Life will waive your premium as of the first of the following month. Premium payments resume on the first day of the month after you are no longer eligible to receive Long-Term Care benefits.

Reinstatement

If your coverage is canceled for nonpayment of premium, you can request reinstatement. You must provide Genworth Life with proof of good health and pay all past-due premiums.

If a severe cognitive impairment or functional impairment caused the default in premium, you may request reinstatement within five months of the cancellation date without having to provide proof of good health. You must provide Genworth Life with proof of the severe cognitive impairment or loss of functional capacity and pay all past due premiums. For definitions of severe *cognitive impairment* and *functional impairment*, see the **Glossary** chapter.

coverage options

Because everyone has different needs and financial priorities, the Long-Term Care Insurance Plan has several options. Your election should reflect the benefit amount you'd like to receive based on where you live or plan to retire.

When you enroll in the plan, you elect a monthly benefit amount, a total lifetime amount, and whether you want to include the nonforfeiture feature. Your options are:

Three-Year Coverage (36 months)			
Monthly Benefit Amounts	**$3,000**	**$6,000**	**$9,000**
Coverage Maximum	$108,000	$216,000	$324,0000

Five-Year Coverage (60 months)			
Coverage Maximum	$180,000	$360,000	$540,000

Monthly Benefit Amount

The monthly benefit is the maximum amount of reimbursement you can receive for each month you're eligible for benefits and receive a covered service. Charges for nursing homes, inpatient hospice care, assisted-living facilities and respite care in a facility are covered up to 100 percent of the monthly benefit amount. Home care, outpatient hospice care and adult day care are all covered at 75 percent of the monthly benefit amount. You can choose from any of the following monthly benefit options:

- $3,000 per month.
- $6,000 per month.
- $9,000 per month.

Coverage Maximum

The coverage maximum is the maximum amount of benefits the plan will pay.

Benefits can last longer than the duration selected, based on the cost of your care, how frequently services are needed and what types of services are used.

For example, if you select the $6,000 monthly benefit and you enter a nursing home that costs only $4,500 a month, the difference of $1,500 remains in your coverage maximum and extends the duration of the plan. Or, if you receive care in your home and are reimbursed at 75 percent of the monthly benefit, the other 25 percent of the monthly benefit remains in your coverage maximum. There are two coverage lengths to choose from:

- 3-year duration (36 times the monthly benefit selected).
- 5-year duration (60 times the monthly benefit selected).

Nonforfeiture Feature

This optional feature at an additional cost allows you to stop paying premiums and still keep a portion of your coverage. If you have paid premiums for at least three years and elect to stop making payments, you'll be entitled to receive a reduced level of coverage.

This feature provides a total lifetime benefit based on the amount of premium paid or 30 days in a nursing facility, whichever is greater.

additional plan features

Regardless of the options you choose, the following special features are provided by the Long-Term Care Insurance Plan.

Inflation Protection

Because the cost of care will most likely rise and may diminish your benefits, the Long-Term Care Insurance Plan includes three inflation protection options.

- **Future Purchase Options:** This benefit will apply if neither of the Automatic options is selected. Every three years, you'll be offered the option to request an increase in your coverage. As long as you choose to increase your coverage once in every two offerings, you can increase your coverage without providing proof of good health. The amount of the increase to the monthly benefit is 5 percent, compounded annually. Any increase in the monthly benefit also increases the total lifetime maximum. However, if you have already received benefits, only the remaining portion of the total lifetime benefit will increase – by that same percentage rate.

  The cost for this increase is based on your age on the effective date of the change in coverage. The offer is not made if the insured is:

  - In claim.
  - Benefit eligible.
  - Receiving benefits.
  - Satisfying the elimination period.

- **Automatic 3% Compound Benefit Increases for Life:** Under this optional rider, the benefit amounts increase automatically each year by 3 percent compounded annually while the insurance is in effect and premiums are paid. There is an additional premium for this rider.

- **Automatic 5% Compound Benefit Increases for Life:** Under this optional rider, the benefit amounts increase automatically each year by 5 percent compounded annually while the insurance is in effect and premiums are paid. There is an additional premium for this rider.

Bed Reservation Benefit

If, while confined in a nursing home, hospice facility or assisted-living facility, you require hospitalization, the Long-Term Care Insurance Plan continues to pay the daily benefit for up to 60 days per calendar year to hold the bed in the nursing home, hospice facility or assisted-living facility, if required.

Guaranteed Renewable

As long as you continue to pay premiums, Genworth Life cannot cancel your coverage.

covered services

The Long-Term Care Insurance Plan covers a wide range of services so that you can choose the care that is best for you.

Privileged Care Coordination Services

Care coordination services are available. Professional care coordinators review the insured's specific situation and develop an appropriate plan of care to meet those needs. The cost of this service is not deducted from the lifetime coverage maximum.

Nursing Home Services

Coverage includes all levels of care, skilled to custodial, received in a licensed nursing home or Alzheimer's facility.

Assisted-Living Facility

Coverage includes licensed facilities providing 24-hour care and other services required by individuals who are unable to perform the activities of daily living or who demonstrate severe cognitive impairment.

Inpatient Hospice Care

Coverage includes health care and support services in a licensed hospice facility for those who are terminally ill.

Home Care

Coverage includes care received at home from a nurse, home health aide or homemaker or from a physical, occupational, respiratory or speech therapist from a licensed home care agency. Care also can be received from a nurse (R.N., registered nurse; L.P.N., licensed practical nurse; or L.V.N., licensed vocational nurse) or therapist who is not from a licensed agency.

Adult Day Care

Coverage includes a licensed facility offering care, health support and rehabilitative services for adults during the day.

At-Home Hospice Care

Coverage includes health care and support services provided at home for those who are terminally ill.

Respite Care

Provides relief for the primary caregiver. Coverage includes care from licensed providers for up to the monthly benefit amount per calendar year.

Alternate Plan of Service

Alternate care expenses not otherwise covered by the Long-Term Care Insurance Plan may be covered when the insured, his or her physician if appropriate, and Genworth Life agree in writing to the alternate care services. Prior approval is required. Genworth Life must determine that the care or services are qualified Long-Term Care services that are cost-effective and appropriate; are consistent with general standards of care; provide an equal or greater quality of care than other services covered the Long-Term Care Insurance Plan; and are clearly specified in the insured's plan of care, and in a separate written mutual agreement.

Home Assistance Benefit

This benefit helps you pay for expenses needed to adjust to your new lifestyle. It can be useful for items such as durable medical equipment, an emergency response system, caregiver training, or home modifications. It is payable after completion of the waiting period and it does not reduce the total lifetime benefit. It is equal to three times your monthly benefit.

To access the home assistance benefit, proof of payment for a covered expense must be submitted to Genworth Life.

Informal Care Benefit

Informal care for maintenance or personal care services provided in the insured's home by someone who does not normally reside there is eligible for a daily benefit up to 1 percent of the monthly nursing facility maximum, up to 30 days per calendar year.

International Facility Care Benefit

Coverage for care and support services, including room and board, provided by a nursing facility located outside of the United States, limited to 75 percent of the monthly benefit, for up to 48 months.

what the plan does not cover

The Long-Term Care Insurance Plan does not provide benefits for the following:

- Care provided for detoxification of, or rehabilitation for, alcohol or drug abuse (chemical dependency), except drug abuse sustained at the hands of, or while being treated by, a physician for an injury or sickness.
- Any service or supply received outside of the United States or its territories, unless specifically provided for in the international coverage benefit.
- Illness, treatment or medical condition arising out of:
  - War or act of war (whether declared or undeclared).
  - Participation in a felony, riot or insurrection.
  - Service in the armed forces or auxiliary units.
  - Attempted suicide (whether sane or insane) or intentionally self-inflicted injury.
- Any care provided while in a hospital, except for confinement in a distinct part of a hospital, which is licensed as a nursing home or hospice.
- Any care provided by or in a Veteran's Administration or Federal government facility, unless a valid charge is made to you.
- Any service provided by your immediate family, unless he or she is an employee of an organization providing you care.
- Any service or supply to the extent that the expenses are reimbursable under Medicare, or would be reimbursable but for the application of a deductible or coinsurance or copayment amount. This exclusion will not apply in those instances where Medicare is determined to be the secondary payer under applicable law.
- Services for which no charge is normally made in the absence of insurance.

You will receive a Certificate of Coverage from Genworth Life within 30 days after you are approved for enrollment the Long-Term Care Insurance Plan. In the event of a conflict between the terms in this document and the Certificate of Coverage, the Certificate of Coverage governs.

changing your coverage

You can request an increase or decrease in your monthly benefit and total lifetime benefit or add or drop the nonforfeiture option at any time. However, once you receive nonforfeiture coverage, you cannot change your benefits. Depending on the type of change you want to make, you may be required to submit proof of good health before your change becomes effective.

Any change in the cost of coverage becomes effective on the first day of the month on or after the date Genworth Life approves the request. If the monthly benefit is increased, the cost for the incremental increase is based on your age on the date the change is effective. For all other coverage increases, the new coverage is based on your age on the date the change is effective. If coverage is decreased, the new cost is based on the age used to determine your previous coverage. When you increase your monthly benefit, the total amount of coverage also increases.

payment of benefits

To qualify for Long-Term Care benefits, Genworth Life must authorize benefits, and a waiting period must be satisfied.

Benefit Eligibility

You are eligible to receive Long-Term Care Insurance Plan benefits only if a licensed health care practitioner certifies that you are chronically ill.

Benefits are payable for services included in a plan of care prescribed by a licensed health care practitioner. If you have disabilities resulting from organic brain diseases, including Alzheimer's disease or similar disorders, you are eligible for benefits. The plan also pays benefits if your dependency results from mental or nervous disorders.

You, your representative or your physician must contact Genworth Life and request an eligibility assessment based on your inability to perform these activities on your own. Genworth Life must approve the request for benefits and also may require access to your medical records to do this. In addition, Genworth Life may require that you be examined by a licensed health care practitioner, at their expense, and may conduct an onsite assessment.

Waiting Period

You must satisfy a 90-day waiting period before benefits are payable.

The waiting period is satisfied by days you are chronically ill, beginning with the first day you incur a covered expense. Some benefits are not subject to the waiting period, including the home assistance benefit and hospice benefits.

Denial of Eligibility for Benefits

If you are not certified as chronically ill, you are not eligible for benefits. Genworth Life will send you a written notice of its decision promptly; after all necessary information is received.

If you require further explanation of the denial, a written request should be sent to Genworth Life. Within 45 days of the date the request is received, Genworth Life will provide a written explanation of the reasons for the denial and make available all information directly relating to such denial. You can appeal Genworth Life's denial of eligibility for benefits.

Concurrent Review

When you are receiving covered services, Genworth Life will review your case from time to time to see that the standards for benefit eligibility are still being met, and may require proof from a licensed health care practitioner, retained by Genworth Life, that you continue to be certified as chronically ill. Genworth Life may review records and may contact you, your physician or a representative familiar with your condition. If it is determined that you are no longer eligible for benefits, Genworth Life will notify you.

how to file a claim for benefits

Genworth Life notifies you of benefit eligibility and provides forms to be used to submit proof of claims for benefits.

How to Submit a Claim

Genworth Life pays benefits only upon receipt of adequate written proof that expenses for covered services were incurred. Written proof of claim must be submitted no later than 90 days after the end of the coverage month in which the expenses were incurred.

Genworth Life will not deny your claim for failure to provide timely proofs of loss if they are provided with this information no later than one year from the date required by the above paragraph. Unless provided with proof that you were incapacitated or incapable of providing Genworth Life with this information within the one year period, or unless prohibited by law, your claim may be denied for failure to provide Genworth Life with proofs of loss within the one year period.

Approval of Claims

If Genworth Life approves a claim for benefits, Genworth Life will send a written notice of the decision promptly after all necessary information is received.

How Benefits Are Paid

After Genworth Life has approved the claim, reimbursement for covered services is paid directly to you. Payments for most services can be made directly to the provider at the request of you and your provider.

Amount of the Benefit

The daily monthly benefit you select determines the maximum amount that can be received each month. The amount payable will not exceed the total amount of expenses incurred for all services received in a day.

Denial of Claims

If Genworth Life denies a claim for benefits, in whole or in part, Genworth Life will send a written notice of its decision promptly after all necessary information is received. Written requests should be sent to Genworth Life if you require a further explanation of the denial. Within 45 days of the date the request is received, Genworth Life will provide a written explanation of the reasons for the denial and make available all information directly relating to such denial. You can appeal Genworth Life's denial of a claim.

Appeal of Claims

Genworth Life will reconsider its decision to deny your eligibility for benefits or your claim for benefits. You must make a written request to Genworth Life for a review of the decision, and this request must be sent within 120 days after you receive the denial. Within 30 days of receiving all necessary information, Genworth Life will review the denial and make a final decision. Its final decision will be in writing, and if a denial, will include the specific reasons.

how to file a claim for eligibility

If you have a question regarding your eligibility to participate in the Long-Term Care Insurance Plan, contact the HR Service Center at 1-888-825-5247. If you are not satisfied with the outcome, you can file a claim by following the procedures described below.

If you have been denied participation in the Long-Term Care Insurance 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
Chevron Corporation Long-Term Care Insurance Plan
Chevron Human Resources Service Center
P.O. Box 18012
Norfolk, VA 23501

If you file a claim for participation in the Long-Term Care Insurance 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 in the Long-Term Care Insurance Plan is denied (in whole or in part), the plan administrator will send you a written explanation that includes:

- Specific reasons for the denial.
- The specific Long-Term Care Insurance 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.

Appeals Procedures for Denied Claims

Regarding Eligibility to Participate in the Long-Term Care Insurance Plan

If your claim for participation in the Long-Term Care Insurance 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 the Long-Term Care Insurance Plan documents, records and other information relevant to your claim for participation in the Long-Term Care Insurance Plan.

The Review Panel will provide you with a written response to the appeal and will either reverse the earlier decision and permit participation in the Long-Term Care Insurance Plan, or it will deny the appeal. If the appeal is denied, the written response will contain:

- The specific reasons for the denial.
- The specific Long-Term Care Insurance Plan provisions or Chevron policy on which the denial is based.
- Information explaining your right to review and receive, at no charge, copies of the Long-Term Care Insurance Plan documents, records and other information relevant to your claim for participation in the Long-Term Care Insurance 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 Long-Term Care Insurance Plan provisions or Chevron policy or to grant exceptions to the Long-Term Care Insurance Plan rules or Chevron policy.

For appeals regarding participation in the Long-Term Care Insurance Plan, address your written correspondence to:

Review Panel
Chevron Corporation Long-Term Care Insurance 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.

when coverage ends

You can cancel your Long-Term Care Insurance Plan coverage at any time. This cancellation is effective at the end of the month in which cancellation is requested.

The following chart shows the circumstances under which Long-Term Care Insurance Plan coverage ends and when the termination is effective.

Circumstance Causing Coverage to End	When Coverage Ends
You request cancellation of your coverage.	At the end of the month in which you notify Genworth Life that you wish to terminate your coverage.
This coverage is replaced by another substantially similar plan, and you become eligible for that coverage.	On that date.
You do not pay the costs for coverage.	On the last day of the month in which Genworth Life received payments.
You reach your maximum lifetime benefit.	On that date.
You die.	On that date.

continuation of coverage

If the Long-Term Care Insurance Plan is terminated, an eligible employee, retiree or family member may continue coverage directly with Genworth Life. To continue coverage, you must pay the required premiums directly to Genworth Life. For more information, contact Genworth Life at 1-800-416-3624.

administrative information

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

Employer Identification Number (EIN)

The employer identification number is 94-0890210.

Plan Sponsor and Plan Administrator

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

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

1-888-825-5247

Chevron Corporation Long-Term Care Insurance Plan
Plan number: 818 **Claims Administrator/Insurer:** Genworth Life ı Group Processing Center ı P.O. Box 64010 ı St. Paul, MN 55164-0010 **Type of Administration:** Insurer administration **Type of Plan:** Long-Term Care Insurance

Agent for Service of Legal Process

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

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

Legal process also can be served on the plan administrator.

Administrative Power and Responsibilities

Chevron Corporation has the discretionary authority to control and manage the administration and operation of the Long-Term Care Insurance 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 health care plans, provided both of the following apply:

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

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

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

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

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

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 Long-Term Care Insurance Plan. Upon any overpayment, the Long-Term Care Insurance Plan shall have a first right of reimbursement and restitution with an equitable lien by contract in such amount.

Furthermore, the holder of such overpayment shall hold it as the plan’s constructive trustee.

If you 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 Genworth Life of the relevant facts. If Genworth Life 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 Genworth Life.

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

Plan Year

The plan year for the Long-Term Care Insurance Plan begins on January 1 and ends on December 31 of each year.

No Right to Employment

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

Future of the Plans

Chevron Corporation has the right to change or terminate a plan, 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.

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.

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

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

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

- If you request a copy of the plan documents or the plan's latest annual report and do not receive them within 30 days, you can file suit in a federal court. In such a case, the court can require the plan administrator to provide the materials and pay you up to $147 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 **Filing a Lawsuit** in this section).

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

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

Assistance With Your Questions

If you have any questions about the plan, you should contact the claims administrator and/or plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You also can obtain certain publications about your rights and responsibilities under ERISA by:

- Calling the Employee Benefits Security Administration publications hotline at 1-866-444-3272;

- Logging on to the Internet at **www.dol.gov/agencies/ebsa**.

Filing a Lawsuit

You can file a lawsuit under section 502(a) of ERISA to recover a benefit under the plan, provided all of the following have been completed:

- You initiate a claim as required by the plan.
- You receive a written denial of the claim.
- You file a timely written request for a review of the denied claim with the plan administrator or Genworth Life (or you receive written notification that the appeal has been denied).

If you don't receive a timely written denial of the claim, the plan administrator reserves the right to contend that you may still not file a legal action until you file a timely written request for a review of the denied claim with the plan administrator or Genworth Life and that review is complete. If you want to take legal action after you exhaust the claims and appeals procedures, you can serve legal process on:

Service of Process
Chevron Corporation
6001 Bollinger Canyon Road
Building T (T-3371)
San Ramon, CA 94583-2324

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

glossary

Activities of Daily Living

- **Bathing** — washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.

- **Dressing** — putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

- **Transferring** — moving into or out of a bed, chair or wheelchair.

- **Toileting** — getting to and from the toilet, getting on or off the toilet and performing associated personal hygiene.

- **Continence** — ability to maintain control of bowel and bladder function or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

- **Eating** — feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously.

Activities of Daily Living

Chevron offers several approved part-time work schedules, including:

- Four 5-hour days (20 hours) per week.

- Five 4-hour days (20 hours) per week.

- Three 8-hour days (24 hours) per week.

- Four 6-hour days (24 hours) per week.

- Three 9-hour days (27 hours) per week.

- Four 7.5-hour days (30 hours) per week.

- Five 6-hour days (30 hours) per week.

You must get management approval to work a part-time schedule.

Assisted Living Facility (for Long-Term Care Insurance)

Assisted living facility means a facility that satisfies all of the following:

- Maintains all appropriate licensing required under the laws of the jurisdiction in which it is located to provide maintenance or personal care.
- Provides 24-hour-a-day care and services sufficient to assist clients with needs that result from the inability to perform activities of daily living or severe cognitive impairment.
- Whose residents are not related to the owner or manager of the facility.
- Has a minimum of six residents.
- Uses aides trained or certified to provide maintenance or personal care in accordance with any laws applicable to the provision of such care.
- Provides 24-hour supervision of clients by a trained and awake staff.
- Has formal arrangements for emergency medical care.
- Maintains written records of services provided to each client.
- Provides clients with three meals a day.
- Has appropriate methods and procedures to assist in administering prescribed drugs where allowed by law.

It is not other than incidentally a hotel, motel, a place for rest or a place for drug addicts or alcoholics. Retirement homes, congregate living, senior housing or other facilities primarily intended to provide residential services but not maintenance or personal care typically do not qualify as an assisted living facility. If an institution has multiple licenses or purposes, only that section of the institution specifically meeting the definition of assisted living facility will qualify as an assisted living facility.

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.

Chronically Ill

Chronically ill means that:

- Because of a loss of functional capacity, you are unable to perform, without substantial assistance from another individual, at least two of the six defined activities of daily living for a period of at least 90 days.
- Because of a severe cognitive impairment, you require substantial supervision to protect you from threats to health and safety.

Cognitive Impairment

Problems with attention, memory or other loss of intellectual capacity that requires supervision to help or protect the impaired person. Depending on the cause, such impairment may be permanent or temporary. Alzheimer's disease is an example of a cognitive impairment.

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.

Corporation
Chevron Corporation.

Domestic Partner
See the **Eligibility** chapter of this summary plan description for the definition of an eligible domestic partner.

Domestic Partnership
See the **Eligibility** chapter of this summary plan description for the definition of a domestic partnership.

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

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

Functional Impairment
Limitations of physical or mental functioning that may affect an individual's capacity for independent living.

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.

Nursing Home (for Long-Term Care Insurance)

Nursing home means a facility that is licensed as a nursing facility under the laws of the jurisdiction in which it is located, or another organization approved by Genworth Life, that satisfies all of the following requirements:

- Has appropriate licensure for a business, under the laws of the jurisdiction in which it is located, that provides maintenance or personal care.
- Has 24-hour a day nursing care.
- Has 24-hour a day maintenance or personal care provided by a trained/certified and awake staff supervised by a nurse.
- Maintains a written record of services provided to each client.
- Has formal arrangements for emergency medical care.
- Services are not limited to provision of food, shelter and other residential services such as laundry.
- Residents are not related to the owner or manager of the facility.
- Is not, other than incidentally, a hospital (except a distinct part of a hospital that is a nursing facility), a residential facility, hotel, motel, place for rest, home for the aged, sheltered living accommodation, facility for the treatment of mental illness, continuing care retirement community or similar entity, or a place for drug addicts or alcoholics.

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.

Plan of Care

A plan prescribed by a licensed health care practitioner that identifies ways of meeting the needs of a person who is chronically ill.

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.

Chevron alternate with school periods.

Regular Work Schedule

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

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

Severe Cognitive Impairment
A deterioration or loss in intellectual capacity that places a person in jeopardy of harming himself, herself or others, and thereby requires that the person receive substantial supervision by another individual. Deterioration or loss must be measured by clinical evidence and standardized tests that reliably measure impairment of short- or long-term memory; orientation to people, places or time; and deductive or abstract reasoning.

Spouse
See the **Eligibility** chapter of this summary plan description for the definition of a spouse.