long-term disability plan

summary plan description

effective january 1, 2017

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This document describes the Long-Term Disability Plan as of January 1, 2017. This plan applies to eligible Chevron employees on the U.S. payroll. The information presented here constitutes the summary plan description (SPD) of the Long-Term Disability Plan as required by the Employee Retirement Income Security Act of 1974 (ERISA). These descriptions don't cover every provision of this plan. Many complex concepts have been simplified or omitted to present a more understandable plan description. 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 to the extent permitted by law.

If you have questions regarding your disability benefits, contact the Human Resources Service Center (HR Service Center) at 1-888-825-5247 (610-669-8595 outside the U.S.).

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

- Enroll in this plan's optional coverage.
- Make open enrollment elections for this plan.
- Ask about your or your dependents' eligibility to participate in this plan.
- If you or an enrolled eligible dependent become eligible for Medicare due to a disability.
- 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 (inside the U.S.)
- 610-669-8595 (outside the U.S.)

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.

Human Resources Service Center (HR Service Center) *and* 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.

Disability Management Program

Why contact this administrator

- Report an illness, injury or disability lasting more than five workdays.
- To apply for job protection under the federal Family Medical Leave Act or other state-eligible leave law.

Phone information

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

Website information

- Go to **hr2.chevron.com** and click the **Disability Management** link.
- You can also go directly to **hr2.chevron.com/disabilitymanagement**.

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

- If you're an eligible employee, you automatically receive Basic Coverage under the Long-Term Disability (LTD) Plan. This coverage can pay disability benefits of up to 40 percent of your annualized regular pay, up to the Internal Revenue Code limit (effective January 1, 2017, this limit is $270,000 but is adjusted based on inflation). If your annualized regular pay is less than $52,500, Chevron pays for minimum Basic Coverage of 60 percent of your annualized regular pay, up to a pay limit of $35,000.

- For off-the-job disabilities, Basic Coverage begins after you complete six months of service from your most recent hire date. For on-the-job disabilities, Basic Coverage begins on your first day of work.

- Chevron currently pays for your Basic Coverage.

- You can purchase additional Optional Coverage equal to the difference between the company-paid coverage and 50 percent or 60 percent of your annualized regular pay, up to the Internal Revenue Code limit. You pay for this coverage.

- For off-the-job disabilities, if you purchase Optional Coverage, it begins after you complete six months of service from your most recent hire date. For on-the-job disabilities, it begins on your first day of work.

- You're covered under the Long-Term Disability Plan in effect when your disability begins, and benefits are based on your annualized regular pay at the time your disability begins.

eligibility

Except as described below, you're generally eligible for Chevron's Long-Term Disability 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 disability leave, short union business 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 on a disability leave, Long-Term Disability coverage continues.
    - If you're on a short union business leave or military service leave, your Long-Term Disability coverage and contributions continue while you're on leave.
- If you're a casual employee, you've worked (or are expected to work) a regular work schedule for more than four consecutive months.
- 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.
- If you're on a family leave or furlough leave, you are not eligible for the Long-Term Disability Plan while you're on leave.
- 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're designated by Chevron as a seasonal employee.
- 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'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 (610-669-8595 outside the U.S.)

You're automatically covered under the Short-Term Disability Plan and you automatically receive Basic Coverage in the Long-Term Disability Plan. If you want Optional Coverage in the Long-Term Disability Plan, you must enroll in order to be covered. For details, see the chapter titled **Participation**.

participation

When and How You Can Enroll

As an eligible employee, you don't need to enroll for Basic Coverage in the Long-Term Disability Plan. You do, however, need to enroll for Optional Coverage in the Long-Term Disability Plan.

Basic Coverage in the Long-Term Disability Plan
Coverage is automatic; you don't need to enroll.

Optional Coverage in the Long-Term Disability Plan
You can enroll within 31 days (without providing proof of good health) after one of the following occurs:

- You become an eligible employee.
- Your salary first reaches a level where you can elect Optional Coverage.

If you enroll after the 31-day period, you must follow the late enrollment procedures. To enroll, contact the HR Service Center.

Late Enrollment Procedures
Late enrollment procedures apply to Long-Term Disability Plan — Optional Coverage. These procedures require that to qualify for coverage, you must provide proof of good health to the claims administrator's delegate. This may involve getting a physical examination (at your own expense). The claims administrator's delegate will review your proof of good and, if it's satisfactory, send you an acceptance letter. Coverage begins on the first day of the month after approval. After the enrollment process is complete, the HR Service Center will send you a confirmation statement.

Making Changes

Basic Coverage in the Long-Term Disability Plan
No changes. You're automatically covered when you become eligible.

Optional Coverage in the Long-Term Disability Plan
If you don't enroll for coverage when you're first eligible and you want to enroll or increase coverage at a later date, you can do so, provided you follow the late enrollment procedures. You're first eligible when you become an eligible employee or when your salary first reaches a level that allows you to elect Optional Coverage. You're notified once your salary reaches the level that makes you eligible for Optional Coverage. You can cancel Optional Coverage at any time. To change or cancel coverage, contact the HR Service Center.

When Participation Begins

Basic Coverage in the Long-Term Disability Plan
Basic Coverage for off-the-job disabilities begins six months from your most recent hire date. Basic Coverage for on-the-job disabilities begins on your first day of work. If you're disabled on the date coverage is scheduled to begin, coverage takes effect once you return to your full regular work schedule. This doesn't apply if you're absent because you're on vacation or a leave of absence with pay, or if you're receiving benefits from the Short-Term Disability Plan for an on-the-job disability.

Optional Coverage in the Long-Term Disability Plan
If you enroll within 31 days after you're first eligible, Optional Coverage begins after you complete six months from your most recent hire date or, if later, on the first day of the month on or after the date your annualized regular pay first makes you eligible for Optional Coverage.

If you enroll after the 31-day period, you must follow late enrollment procedures (in which case, coverage begins on the later of the day you complete six months of service from your most recent hire date or on the first of the month after approval of your enrollment).

If you're disabled on the date coverage is scheduled to begin, coverage takes effect once you return to your full regular work schedule. This doesn't apply if you're absent because you're on vacation or a leave of absence with pay, or if you're receiving benefits from the Short-Term Disability Plan for an on-the-job disability.

When Participation Ends

Basic Coverage in the Long-Term Disability Plan

Your plan participation ends under the following certain circumstances:

- Your health and welfare eligibility service as an eligible employee ends.
- You no longer qualify as an eligible employee due to a reduction in your regular work schedule or otherwise.
- Your health and welfare eligibility service as an eligible employee is suspended. Coverage is suspended if you're absent from work due to a leave of absence without pay, a strike or a layoff, or if you transfer to a Chevron subsidiary that doesn't participate in the plan. If you return to work immediately after your service is suspended, your coverage begins again.
- The plan is terminated.

If you're disabled when your coverage ends or is suspended, your eligibility for benefits for that disability isn't affected. Plan benefits aren't payable for a disability that begins after coverage ends or while coverage is suspended.

Optional Coverage in the Long-Term Disability Plan

Your plan participation ends under the following certain circumstances:

- Your health and welfare eligibility service as an eligible employee ends.
- You no longer qualify as an eligible employee due to a reduction in your regular work schedule or otherwise.
- Your health and welfare eligibility service as an eligible employee is suspended. Coverage is suspended if you're absent from work due to a leave of absence without pay, a strike or a layoff, or if you transfer to a Chevron subsidiary that doesn't participate in the plan. If you return to work immediately after your service is suspended, your coverage begins again.
- Your annualized regular pay drops below the level for Optional Coverage.
- You stop making the required contributions.
- The plan is terminated.

If you're disabled when your coverage ends or is suspended, your eligibility for benefits for that disability isn't affected. Plan benefits aren't payable for a disability that begins after coverage ends or while coverage is suspended.

Special Participation Rules for Former Unocal Employees

If you're a former Unocal employee who is an eligible employee, your participation began on July 1, 2006. These rules apply:

- If you were enrolled in the Unocal Long-Term Disability Plan on June 30, 2006, and your annualized regular pay was over $35,000, you automatically were enrolled for Basic Coverage and Optional Coverage in the Long-Term Disability Plan at 60 percent of annualized regular pay.

- If you were not enrolled in the Unocal Long-Term Disability Plan on June 30, 2006, and your annualized regular pay was over $35,000, you automatically were enrolled for Basic Coverage in the Long-Term Disability Plan. You were eligible to enroll for Optional Coverage during the initial open enrollment period without providing proof of good health.

- If your annualized regular pay was $35,000 or less, you automatically were enrolled for Basic Coverage at 60 percent of annualized regular pay.

Special Participation Rules for Former Atlas Employees

- If you're a former Atlas employee who is an eligible employee, your participation began on the later of your payroll transfer date in 2011 or the date you were next actively at work on or after the payroll transfer date.

- If, on your payroll transfer date, you were either disabled under the terms of the long-term disability coverage sponsored by Atlas (referred to as the "Atlas Plan") or in the elimination period for disability benefits under the Atlas Plan, you are not eligible for benefits for that disability under the Chevron Long-Term Disability Plan, but may be eligible for disability benefits paid by Sun Life Assurance Company of Canada in accordance with the terms of Policy 212056, as in effect under the Atlas Plan.

- The exclusion of disabilities resulting from condition(s) that you received care, treatment or consultation for during the three-month period just before you became covered under the plan does not apply for former Atlas employees who began participating on the later of your payroll transfer date in 2011 or the date you were next actively at work on or after the payroll transfer date.

Proof of Good Health

If you decide not to purchase Optional Coverage in the Long-Term Disability Plan when you're first eligible and you want to enroll at a later date, or if you decide to increase your Optional Coverage from 50 percent to 60 percent, you need to follow late enrollment procedures and provide proof of good health. (currently in the form of a Medical History Statement). When you provide proof of good health, you must satisfactorily answer enrollment questions and, in certain instances, provide answers to a supplemental health questionnaire or get a physical examination.

You will need the following information to complete the proof of good health:

- Group Name: Chevron Corporation
- Group ID: 10119770
- Six-digit policy number: 146541
- Online: **www.standard.com/mybenefits/mhs_ho.html**
- Printable: **www.standard.com/forms/ebid/mhsonly/**

how much you pay for coverage

The chart below shows how you pay for each of the disability plans.

Plan	How Much You Pay for Coverage
Long-Term Disability Plan	
• Basic Coverage	Currently, no cost to you.
• Optional Coverage	You pay the entire cost of this coverage through regular payroll deductions on an after-tax basis.

Your Optional Coverage contributions change automatically when your pay changes. The cost of coverage changes from time to time. For current cost information, you can contact the HR Service Center. Your annual open enrollment materials also include the most up-to-date plan costs.

If you become disabled, you must continue your contributions during the plan's elimination period. If you stop contributing during the elimination period, your Optional Coverage ends for any disability other than the one you have at the time your contributions stop. While you're receiving benefits, you don't pay for coverage.

Here is an example of how the cost of Optional Coverage is determined:

Example— Cost of Optional Coverage in the Long-Term Disability Plan
If your annualized regular pay is $70,000 and you elect 60 percent Optional Coverage:

Basic Coverage

- $70,000 x 40 percent
- $70,000 x 40 percent = $28,000 (Basic Coverage gross annual benefit)

60 Percent Optional Coverage

- $70,000 x 60 percent minus $28,000 Basic Coverage benefit
- $70,000 x 60 percent = $42,000 – $28,000 = $14,000 (Optional Coverage gross annual benefit)
- Annual cost = $14,000 ÷ 100 = 140 x $1.27* = $177.80
- Monthly cost = $177.80 ÷ 12 = $14.82

*Cost amounts represent rounded figures and reflect 2017 rates, which are subject to change in the future.

disability defined

During the elimination period and during the first 24 months that you receive benefits from the plan, you're considered totally disabled if:

- An injury or illness prevents you from performing the material and substantial duties of your usual occupation at Chevron (or another job at Chevron for which you're reasonably trained, qualified or experienced).

- You're under the care of a doctor or licensed physician.

After you receive benefits from the plan for 24 months, you're considered totally disabled and eligible for continuing benefits if you meet all of the following qualifications:

- You're unable to perform the duties of any gainful occupation (including self-employment) for which you're qualified — or may reasonably become qualified because of your education, training or experience (whether or not such a job is available).

- You're receiving Social Security disability benefits — or have applied for benefits, requested an appeal if benefits were denied, and cooperate fully with the LTD claims administrator's Social Security assistance vendor, including providing any requested information during all stages of appeals.

- You're under the care of a doctor or licensed physician.

The plan's claims administrator, in its sole discretion, determines whether your condition is a disability that entitles you to benefits under this plan, and plan benefits may be reduced, limited or stopped if special circumstances occur. No benefits are payable for disabilities that aren't covered under the plan. In addition, benefits are limited if a disability is a result of mental illness, alcoholism, drug addiction or the use of hallucinogenic drugs. See **Benefit Limitations** in the chapter titled **What the Plan Doesn't Cover** for further details.

about the disability management program

The Disability Management Program is offered through ReedGroup, the claims administrator for the Short-Term Disability and Long-Term Disability plans. The program is designed to help you return to work quickly and safely after an illness or injury. The Disability Management Program:

- Advises you whether your absence qualifies under FMLA or a related state law.
- Sends you information, such as medical release forms and legal notices under FMLA or related laws in the state where you work.
- Tracks your time off so that you can get any legal job protection that you're eligible for under FMLA or a related state law.
- Certifies the reason for your absence so that you can receive the disability benefits you may qualify for when you are absent more than five consecutive scheduled workdays.
- Works with you, your supervisor and your licensed physician to facilitate your return to appropriate work as quickly and safely as possible after an illness or injury.
- Assists you with getting benefits you're eligible for if you have a long-term disability, including benefits from Social Security.

Contact the Disability Management Program vendor, ReedGroup, to request an FMLA or other state-eligible leave or if your illness, injury or disability lasts more than five scheduled workdays.

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

For more information about the Disability Management Program, visit the Disability Management website at **hr2.chevron.com/disabilitymanagement**.

when benefits are paid

If you're disabled, benefits can begin after the elimination period.

What Is the Elimination Period?

The elimination period ends on one of the following dates, whichever is later:

- The date you have been disabled for 180 calendar days.
- The date your Short-Term Disability Plan and earned vacation benefits run out.

Recurring Disabilities

If you return to work after a disability and the same disability recurs within 180 calendar days, you may not need to start a new elimination period in the following situations:

- If you don't complete the elimination period and you return to work, but the disability recurs within 30 calendar days, you'll be credited for the first period of disability if it lasted at least seven calendar days.
- If you return to work but you're unable to perform all the duties of your usual occupation, you can receive credit for the first period of disability if the entire period of time since the start of your disability does not exceed twice the applicable elimination period.
- If you complete the elimination period but again return to work, you can receive plan benefits if your disability occurs again.

how much the plan pays

Benefits are based on your annualized regular pay at the time your disability begins. If you qualify for plan benefits, you could receive benefits based on your Basic Coverage and Optional Coverage.

Long-Term Disability Plan Benefits

The chart below shows how you can receive benefits based on your Basic Coverage and Optional Coverage.

Plan	Coverage for You
Long-Term Disability Plan — Basic Coverage (company-paid)	40% of your annualized regular pay (up to the IRS limit*) **or** 60% of your annualized regular pay up to $35,000 (if your annualized regular pay is $52,500 or less)
Long-Term Disability Plan — Optional Coverage (employee-paid)	Additional coverage that, when combined with the company-paid Basic Coverage, provides you with a total of 50% or 60% of your annualized regular pay (up to the IRS limit*)

* For 2017, the IRS limit, which is adjusted based on inflation, is $270,000.

For Basic Coverage and Optional Coverage in the Long-Term Disability Plan, the maximum monthly benefit you can receive is $13,500 and the maximum covered annualized regular pay is $270,000 (effective January 1, 2017, but this limit is adjusted based on inflation).

The amount of Basic Coverage and the amount of Optional Coverage you can purchase depends on your annualized regular pay. Here are some examples of how Basic Coverage and Optional Coverage are determined.

Example 1 — Your annualized regular pay is $35,000

Basic Coverage — The Basic Coverage benefit will be 60 percent of $35,000:

- $35,000 x 60 percent = $21,000 (Basic Coverage gross annual benefit)

Optional Coverage — If your annualized regular pay is $35,000 or less, you are not eligible to purchase Optional Coverage. You will automatically be covered at 60 percent under the Basic Coverage minimum benefit amount.

Example 2 — Your annualized regular pay is $40,000

Basic Coverage —The Basic Coverage benefit will be 60 percent of $35,000:

- $35,000 x 60 percent = $21,000 (Basic Coverage gross annual benefit)

Plus Optional Coverage — If your annualized regular pay is $42,000 or less, you are eligible to purchase only the 60 Percent Optional Coverage benefit because the 50 Percent Optional Coverage benefit amount is equal to or below the Basic Coverage minimum benefit amount.

60 Percent Optional Coverage:

- 60 percent of $40,000 minus the $21,000 Basic Coverage benefit.
- $24,000 – $21,000 = $3,000 (60 percent Optional Coverage gross annual benefit)

Example 3 — Your annualized regular pay is $50,000

Basic Coverage — The Basic Coverage benefit will be 60 percent of $35,000:

- $35,000 x 60 percent = $21,000 (Basic Coverage gross annual benefit)

Plus Optional Coverage — You can purchase 50 Percent **OR** 60 Percent Optional Coverage.

50 Percent Optional Coverage:

- 50 percent of $50,000 minus the $21,000 Basic Coverage benefit
- $25,000 – $21,000 = $4,000 (50 Percent Optional Coverage gross annual benefit)

60 Percent Optional Coverage:

- Benefit will be 60 percent of $50,000 minus the $21,000 Basic Coverage benefit
- $30,000 – $21,000 = $9,000 (60 Percent Optional Coverage gross annual benefit)

Example 4 — Your annualized regular pay is $70,000

Basic Coverage —The Basic Coverage benefit will be 40 percent of $70,000:

- $70,000 x 40 percent = $28,000 (Basic Coverage gross annual benefit)

Plus Optional Coverage — You can purchase 50 Percent **OR** 60 Percent Optional Coverage.

50 Percent Optional Coverage:

- 50 percent of $70,000 minus the $28,000 Basic Coverage benefit
- $35,000 – $28,000 = $7,000 (50 Percent Optional Coverage gross annual benefit)

60 Percent Optional Coverage:

- 60 percent of $70,000 minus the $28,000 Basic Coverage benefit
- $42,000 – $28,000 = $14,000 (60 percent Optional Coverage gross annual benefit)

Income From Other Sources

The plan is designed to ensure that you can receive total disability income of up to 60 percent of your pay at the time you become disabled. As a result, plan benefits are reduced by the amount of income you receive (or are qualified to receive) from certain other sources, including:

- State, federal and any foreign governmental disability benefits.
- Social Security disability benefits payable to you and other members of your family as a result of your disability.
- Veteran's benefits due to disability — unless the veteran's benefits reduce the veteran's pension benefits which would have been paid if the disability had not occurred.
- Social Security retirement benefits paid to you and other members of your family. If you've reached your full Social Security retirement age and you haven't applied for benefits, estimated retirement benefits are offset.
- Workers' compensation and disability payments required by law including, but not limited to, amounts paid for maintenance or cure; except in the case of Workers' Compensation, the offset shall be limited to payments that are attributable to salary continuation benefits
- Federal, state or foreign government-required disability benefits.
- Chevron vacation, holiday and Short-Term Disability Plan benefits.
- An award or settlement that you receive or are eligible to receive from a third party if the Claims Administrator determines that such amount is for wages lost because of a disability caused by the third party.
- Benefits under any disability benefits program for which Chevron or any other employer permits payroll deductions or makes contributions or direct payments.
- Benefits from the Chevron Retirement Plan or any other pension or annuity plan to which the corporation has contributed.
- Veteran's benefits due to disability — unless the veteran's benefits reduce the veteran's pension benefits which would have been paid if the disability had not occurred.

Social Security and LTD Benefits

Plan benefits are reduced by the amount of any Social Security disability benefits you receive or are eligible to receive. This rule also applies to Social Security benefits payable to your dependents as a result of your disability.

It's very important that you apply for Social Security disability benefits as soon as possible after you become disabled, because your plan benefits could be stopped after 24 months if you still aren't receiving Social Security benefits. Social Security benefits can begin after you've been disabled for five months, but it may take much longer to complete the Social Security claims filing process.

The claims administrator's Social Security assistance vendor assists you in filing for Social Security. If the initial request is denied, the vendor works with you to appeal the decision. If the request for benefits continues to be denied, the vendor helps you to obtain a hearing at the Administrative Law Judge level, if appropriate. Once you receive your Social Security benefits, the claims administrator continues working with you to provide information, counseling and education on financial incentives and program benefits that may be available to you.

If your claim for Social Security benefits hasn't been approved by the time your plan benefits start, the plan's claims administrator will estimate the amount of your Social Security benefit and reduce (or offset) your plan benefit by that estimated amount. However, this estimated offset won't be made if you agree in writing to reimburse the plan for any overpayment that results when your claim for Social Security benefits is approved.

When Social Security notifies you of your actual benefit amount, your Long-Term Disability Plan benefit is adjusted and you either receive a check to correct any underpayment or you reimburse the plan for any overpayment.

Your plan benefits will stop if you're still not receiving Social Security disability benefits after you've received plan payments for 24 months and either of the following applies:

- The plan's claims administrator determines that you didn't apply for Social Security benefits in a timely manner.

- If Social Security benefits are denied, you don't complete at least one level of appeal or cooperate fully with the claims administrator's Social Security assistance vendor and supply all requested information during all stages of appeals.

Your benefits will resume if you're still disabled, you provide information that shows you applied for Social Security benefits in a timely manner, and Social Security has made a final determination about your eligibility. If Social Security denies your claim, you must request a review of your claim through Social Security's appeals process.

Note: After you start receiving plan benefits, any general increases in Social Security benefits (or other legal disability benefits) won't further reduce your plan benefits. However, if your Social Security income decreases, your plan benefits will be increased (up to the plan's benefit maximums) to make up for the reduction. If your Social Security benefits are approved retroactively through the services of a lawyer, plan benefits generally won't be reduced by the portion of your award that represents your lawyer's fees but you do have to reimburse the plan the full retroactive Social Security payment amount.

Chevron Retirement Plan Benefits

If you elect to receive benefits from the Chevron Retirement Plan or any similar retirement plan to which Chevron contributes, your LTD benefits are reduced by the amount of benefits which are not attributable to your own contributions (if any). If you elect any monthly annuity option, the actual gross monthly amount you receive (minus any portion attributable to your contributions) will be offset. If you elect a lump sum option, the amount as calculated under the single life annuity option (minus any portion attributable to your contributions), will be offset. Receiving benefits from the Employee Savings Investment Plan (ESIP) does not affect LTD benefits.

If you are overpaid LTD benefits for any reason, you'll be required to repay the amount of the overpayment. If you were underpaid for any reason, you'll be reimbursed the amount of the underpayment.

how long benefits can be paid

Plan benefit payments usually continue until one of the following occurs:

- You're no longer disabled.
- You reach age 65 — unless plan benefits begin on or after your 60th birthday, in which case benefits can be paid for up to five years.
- You elect to receive (or roll over) a lump sum or a monthly annuity from the Chevron Retirement Plan ("Retirement Plan") or any similar retirement plan to which Chevron contributes with an annuity start date prior to January 1, 2011.

  Note: Your Long-Term Disability Plan benefits will not stop if you receive a lump-sum distribution under the Retirement Plan's automatic cash-out provision ($1,000 or less for distributions made on or after March 28, 2005).
- You become ineligible for benefits.
- You die.

Plan benefits may be reduced or stopped if any one of the following situations occurs:

- Your disability is a result of mental illness, alcoholism, drug addiction or the use of hallucinogenic drugs.
- You can't meet the definition of disability that applies after you've received plan benefits for 24 months.
- The income you receive from other sources (see **Income From Other Sources** in the chapter titled **How Much the Plan Pays**) totals more than the coverage level you had at the time you became disabled.
- You refuse to be examined by an independent medical specialist appointed by the plan's claims administrator.
- You refuse reasonable medical treatment or aren't under the care of a doctor or licensed physician.
- You fail or refuse to provide requested information about your claim in a timely manner.
- You refuse to comply with the terms of a Vocational Rehabilitation and Return-to-Work Assistance Program developed for you by the plan's claims administrator.
- You become self-employed or begin work with another employer without first getting approval from the plan's claims administrator.

- You do not claim plan benefits within 24 months after the earlier of the date your disability begins or the date your employment with the company ends.

- You take a rehabilitative job and your income (including plan benefits, Social Security benefits and the pay you receive for the rehabilitative work) exceeds certain limits.

- If your condition lets you perform the normal work duties of your usual occupation but your job changes, you're considered totally disabled for the new job only if one of the following events occur:

  – You would be considered totally disabled from your previous assignment.

  – You worked in the new job on every scheduled workday for a 90-day period without losing time due to your condition.

what the plan doesn't cover

The plan pays limited benefits for certain types of disabilities. And, in some instances, the plan does not pay benefits.

Benefit Limitations

The plan pays limited benefits when disability results from mental illness, alcoholism, drug addiction or the use of hallucinogenic drugs. In these cases, the following rules apply:

- You must participate in a regular, medically supervised treatment program in order to qualify for benefits during the first 24 months of your disability.
- After 24 months of disability, the plan pays benefits only if you're confined to a state-licensed hospital for inpatient care for at least 14 consecutive days. Benefits are payable only during hospitalization and for up to 90 days following release from the hospital.
- If you're hospitalized and released more than once, plan benefits are payable for a maximum of 180 days.

Disabilities That Aren't Covered

Some kinds of disabilities aren't covered under the plan. For example, the plan won't pay benefits, even if you're disabled, if your disability results from any of the following:

- Active participation in an insurrection, war or any act of war, whether declared or not.
- Active participation in the commission of any unlawful act or riot.
- Attempted suicide or intentionally self-inflicted injury, while sane or insane
- Service in the armed forces of any country or international authority.
- Engaging in a fight, unless the claims administrator determines that the actions constituted self-defense against an unprovoked assault.
- Failure to comply with health or safety regulations of the company.
- Working for others or in self-employment.
- A condition(s) that you received care, treatment or consultation for during the three-month period just before you became covered under the plan. This exclusion period lasts until you have been covered under the plan for a 12-month period without being absent from work because of the condition. However, this exclusion does not apply for former Unocal employees who began participating on July 1, 2006.

special disability benefit

After receiving plan benefits for 24 or more months, you may be eligible for a Special Disability Benefit if you can't meet the more rigid definition of Totally Disabled and you meet all of the following requirements:

- You have received benefits under the plan for 24 or more months but subsequently fail to qualify as Totally Disabled.
- Your condition doesn't permit you to resume your usual occupation.
- Your employment with Chevron ends because a suitable position within Chevron isn't available.
- You have completed one or more years of health and welfare eligibility service before your Short-Term Disability Plan benefits and earned vacation time ran out.

You're not eligible for a Special Disability Benefit if your health and welfare eligibility service ends before Long-Term Disability Plan benefits stop, you refuse to accept a suitable job with Chevron, or you die.

The plan administrator has the sole discretion to determine whether you are eligible for a Special Disability Benefit.

Payment of the Special Disability Benefit is made after benefits from this plan end and your employment ends because Chevron determines that there's no suitable job for you at Chevron. See **How a Special Disability Benefit Is Calculated** to determine how much your Special Disability Benefit could amount to.

How a Special Disability Benefit Is Calculated

Special Disability Benefits are paid in a lump sum. Your benefit equals one week of annualized regular pay at the time your disability began. It's then multiplied by your completed years of health and welfare eligibility service (up to a maximum of 25 years) when plan benefits end and is then rounded to the next higher $100. For purposes of calculating the Special Disability Benefit, your annualized regular pay is limited to the Internal Revenue Code compensation limit ($270,000 in 2017). However, if you're enrolled in the LTD Restoration Plan, the limit on your annualized regular pay is $500,000.

The Special Disability Benefit may be limited:

- **If your plan benefits are overpaid for any reason:** Your Special Disability Benefit is reduced by the amount of the overpayment.
- **If you're eligible for retroactive reinstatement of monthly plan benefits:** Your benefits don't start again until you repay any Special Disability Benefit you received.

You may be asked to sign an agreement to repay a portion of your Special Disability Benefit if you're rehired by Chevron. The repayment equals your Special Disability Benefit minus the earnings you would have received from your old job if you had worked in that job from the time your monthly plan benefits ended until your re-employment date.

working while disabled

The plan makes it possible for you to work (including self-employment) and continue to receive benefits if you get advance approval from the claims administrator. If you start working without getting advance approval, your plan benefits stop.

The claims administrator offers a Vocational Rehabilitation and Return-to-Work Assistance Program. To be eligible for the program's rehabilitative services and benefits, you must be medically able to engage in a return-to-work program.

To determine whether or not you're medically able to participate, rehabilitation professionals review your medical and vocational information and decide whether such a program might help you return to gainful employment. If you're eligible to participate, you receive an appropriate written Vocational Rehabilitation and Return-to-Work Assistance Program developed specifically for you (you're reimbursed for any expenses connected with the approved plan). You must comply with the program's terms in order to receive Long-Term Disability Plan benefits. The program may call for the following return-to-work scenarios.

- **Rehabilitative Work:** This is a job that may lead to an eventual return to self-supporting employment. If you return to rehabilitative work, you will be considered to meet the definition of disability under the Long-Term Disability Plan and can continue to receive plan benefits for up to 24 months. During your first year of rehabilitative work, your Long-Term Disability Plan benefits are not offset by your work earnings; however, benefits are reduced if your total earnings from your job, the plan and Social Security disability benefits (primary and family) equal more than your annualized regular pay at the time you became disabled. During your second year of rehabilitative work, your Long-Term Disability Plan benefits are reduced by an amount equal to 50 percent of your rehabilitative work earnings, and benefits are further reduced if your total income exceeds 80 percent of your annualized regular pay at the time you became disabled.

  Note: If your disability began on or before December 31, 1997, different rules apply to rehabilitative work. You can work in a rehabilitative job for one year without the job being considered a return to work, which would end your benefits. Benefits are reduced by 60 percent of your earnings from rehabilitative work.

- **Nonrehabilitative Work:** This is a job that you can do while you're disabled. This type of work isn't intended to help you return to self-supporting employment. The claims administrator determines if a job meets the definition of "nonrehabilitative work."

  If you return to nonrehabilitative work, your Long-Term Disability Plan benefits are reduced by the amount you're paid to do the work.

- **Reduced Work Schedule at Chevron:** If you can return to work on a reduced work schedule while you're recovering from a disability, the plan pays partial benefits. ReedGroup, the plan's claims administrator, and your supervisor must approve your reduced work schedule. Your management must be able to accommodate the reduced schedule, and it should be expected that you would be able to return to full-time work.

  If you return to work on a reduced work schedule during the first 24 months that you receive Long-Term Disability Plan benefits, you can receive plan benefits, provided you meet both of the following requirements:

  - You were totally disabled and absent from work for at least seven consecutive days before you started the reduced work schedule.

  - You're expected to gradually recover from your disability and return to your regular full-time work schedule.

If you return to work on a reduced work schedule, your Long-Term Disability Plan benefits are not offset by your reduced work earnings; however, benefits are reduced if your total earnings from your job, the plan and Social Security disability benefits (primary and family) equal more than your annualized regular pay at the time you became disabled.

You can work a reduced work schedule and continue to receive LTD benefits per these reduced work schedule rules until the earlier of the following:

- The date that the claims administrator determines that you're no longer expected to resume your full regular work schedule.

- 365 calendar days from the date you began to work a reduced regular work schedule.

If you continue to work the reduced work schedule, the reduced schedule becomes your regular schedule. This means that your regular pay and benefits will be prorated based on the new schedule and your Long-Term Disability benefits will end. If you do not continue working, you can continue to receive LTD Plan benefits if you otherwise qualify.

claims and appeals

You must file a claim and follow a specific process to ensure that you receive benefits in a timely manner. This chapter highlights how you file a claim for Long-Term Disability Plan (LTD) benefits or appeal a benefit decision.

Claiming Benefits
For an off-the-job disability, you must notify the claims administrator early in the disability process. The claims administrator assigns any claims with an expected duration of more than six months to a special claims unit. They will send you any necessary paperwork, including a more detailed authorization and LTD claim forms. You must complete and return the forms to file a LTD claim.

For on-the-job disabilities, the Workers' Compensation group manages your disability. If notified by Worker's Compensation, the claims administrator will send you an LTD claim form and an authorization form to release information. You'll need to sign and return the forms in order to start the claim. Then, information between the Workers' Compensation group and the claims administrator will be shared so that duplication of requests will not occur.

In either case, if you do not receive claim forms, you are responsible for contacting the claims administrator to request them. The claims administrator must receive the forms from you in order for a claim to be considered filed. If you have any questions about the process, or wish to request forms to file a LTD claim, call the claims administrator at 1-888-825-5247 (610-669-8595 outside the U.S.).

You must claim plan benefits within two years of the date your disability begins.

Under normal circumstances, the claims administrator sends you written notice of its decision on your claim within 45 days after your completed claim form has been received. Sometimes, though, more time is needed due to matters beyond the plan's control. In such instances, the determination period can be extended for up to an additional 30 days. You must be notified of the reason for the delay before the original 45-day period expires. You also must be notified of when the claims administrator expects to make a decision. If, before the end of the 30-day extension period, the claims administrator determines that, due to matters beyond the control of the plan, a decision can't be reached within the 30-day extension period, another extension of up to an additional 30 days may be requested. You must be notified of the reason for the delay before the original extension period expires. You also must be provided a date as to when the claims administrator expects to make a decision.

In the case of any extension, the notice of extension explains the standards on which plan benefits are based, the unresolved issues that prevent a decision on the claim, and the additional information that's needed to resolve those issues. You have at least 45 days to provide the specified additional information.

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

- The reason(s) for the denial and the specific plan provision(s) upon which the denial was based.
- A description of any additional material or information that's needed to complete the claim and an explanation of why such material or information is needed.
- An explanation of the plan's appeals procedures and the time limits that apply to them (including a statement of your right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

Sometimes, a claim is denied based on an internal rule, guideline, protocol or other similar criterion. If this happens, the notice includes a copy of the rule, guideline, protocol or other similar criterion that was relied upon in denying the claim, or the notice includes a statement that such internal rule, guideline, protocol or other similar criterion was relied upon in denying your claim and you can obtain a copy of the internal rule, guideline, protocol or other similar criterion free of charge, upon request.

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

Appeals Procedures

The claims administrator doesn't have the authority to change the plan provisions or grant exceptions to the plan rules.

If your claim for Long-Term Disability Plan benefits is denied (in whole or in part), you can appeal the denial in writing within 180 days after you receive the claims administrator's written notice that your claim is denied. To appeal the denial of a claim, send written correspondence to:

ReedGroup, Ltd.
PO Box 6248
Broomfield, CO 80021
Fax: 1-866-828-4967

As part of the appeals procedures, you can:

- Submit written comments, documents, records and other information relevant to your claim.
- Upon request and free of charge, be provided reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim.

The claims administrator reviews your claim, taking into account all comments, documents, records and other information you submit relevant to your claim (without regard to whether such information was submitted or considered in the initial benefit determination). The claims administrator provides you with a written response to the appeal and either reverses the earlier decision and provides for the full or partial payment of the part of the claim that was initially denied or confirms the denial.

As part of the appeals procedure, the following procedures apply:

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

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

- The health care professional engaged for the purpose described above will be an individual who neither is an individual who was consulted in connection with the denial of the claim that is the subject of the appeal nor is the subordinate of such individual.

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

The claims administrator reviews and decides the appeal within 45 days after the plan receives the appeal request. If, because of special circumstances, the claims administrator can't reach a decision within 45 days, the review period can be extended for up to an additional 45 days. You must be notified of the reason for the delay before the original 45-day period expires, and you must receive a date as to when the claims administrator expects to make a decision. Once a decision on the appeal is reached, you're notified in writing of the decision before the end of the 45-day period (or the 90-day period, in the event of an extension).

If your appeal is denied, the notice states the reasons for the denial (including references to specific plan provisions upon which the denial was based). It also includes a statement of your right to bring a civil action under section 502(a) of ERISA. For details, see **Enforce Your Rights, Filing a Lawsuit**, in the chapter titled **Your ERISA Rights**.

The notice states that you're 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 disability benefits.

Sometimes, an appeal is denied based on an internal rule, guideline, protocol or other similar criterion. If this happens, the notice includes a copy of the rule, guideline, protocol or other similar criterion that was relied upon in denying the claim, or the notice includes a statement that such internal rule, guideline, protocol or other similar criterion was relied upon in denying your claim and you can obtain a copy of the internal rule, guideline, protocol or other similar criterion free of charge, upon request.

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

how to file a claim for eligibility

If you have a question regarding your eligibility to participate in the Long-Term Disability 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 (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 you believe you are entitled to credit for health and welfare eligibility service in the Long-Term Disability 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
Long-Term Disability Plan Administrator
P.O. Box 18012
Norfolk, VA 23501

If you file a claim for participation or for credit for health and welfare eligibility service in the Long-Term Disability 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 Long-Term Disability 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 Long-Term Disability 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 or Credit for Health and Welfare Eligibility Service in the Long-Term Disability Plan

If your claim for participation or for credit for health and welfare eligibility service in the Long-Term Disability 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 Long-Term Disability Plan documents, records and other information relevant to your claim for participation or for credit for health and welfare eligibility service in the Long-Term Disability 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 Long-Term Disability 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 Long-Term Disability Plan provisions or Chevron policy on which the denial is based.
- Information explaining your right to review and receive, at no charge, copies of Long-Term Disability Plan documents, records and other information relevant to your claim for participation or for credit for health and welfare eligibility service in the Long-Term Disability 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 Disability Plan provisions or Chevron policy or to grant exceptions to the Long-Term Disability Plan rules or Chevron policy.

For appeals regarding participation or credit for health and welfare eligibility service in the Long-Term Disability Plan, address your written correspondence to:

Review Panel
Chevron Corporation Long-Term Disability 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.

administrative information

This chapter 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.)

Note: If you have questions regarding the disability plans, please contact the claims administrator directly. Also note that Chevron has delegated to the claims administrator certain responsibilities for claims and disability management.

Chevron Corporation Long-Term Disability Plan

Plan number: 700

Trustee:

State Street Bank & Trust Co. | 2 Avenue de Lafayette, 2nd Floor | Boston, MA 02111

Claims Administrator:
ReedGroup, Ltd. | P.O. Box 6248 | Broomfield, CO 80021

Type of Administration: Contract administration

Source of Contributions: Employer and employee contributions. All contributions to the Long-Term Disability Plan are held in a trust fund set up to provide long-term disability benefits and to pay plan expenses.

Type of Plan: Disability Benefit

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

Administrative Power and Responsibilities

Chevron Corporation has the discretionary authority to control and manage the administration and operation of the Long-Term Disability 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 Long-Term Disability Plan, provided both of the following apply:

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

Generally, Chevron's collective bargaining agreements don't mention specific plans or benefits. They merely provide that Chevron will extend to its employees who are members of the collective bargaining unit, the employee benefit 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 claims administrator in writing. If it's found that you or a beneficiary wasn't paid benefits you or your beneficiary was entitled to, the plan will pay the unpaid benefits.

Similarly, if the calculation of your or your beneficiary's benefit results in an overpayment, you or your beneficiary will be required to repay the amount of the overpayment to the plan.

The claims administrator may make reasonable arrangements with you for repayment, such as reducing future benefits under the plan from which you received the overpayment.

Recovery of Overpayments

An "overpayment" is any payment made to you (or elsewhere for the benefit of you in excess of the amount properly payable under the Long-Term Disability Plan. Upon any overpayment, the plan shall have a first right of reimbursement and restitution with an equitable lien by contract in such amount.

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

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

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

Plan Year

The plan year for the Long-Term Disability 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. For the Long-Term Disability Plan, certain rules apply as to what happens when a plan is changed, terminated or merged.

- Claims incurred before the date the plan is changed or terminated won't be affected.
- Claims incurred after the date the plan is changed will be subject to such change.
- Claims incurred after the date the plan is terminated won't be covered.

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 chapter 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 chapter).

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

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

Assistance With Your Questions

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

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

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

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

Filing a Lawsuit

You can file a lawsuit to recover a benefit under a plan provided the action is commenced within the applicable statute of limitations period 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 you don't receive a timely written denial of the claim, the plan administrator reserves the right to contend that you may still not file a legal action until you file a timely written request for a review of the denied claim with the appropriate claims administrator and that review is complete. If you want to take legal action after you exhaust the claims and appeals procedures, you can serve legal process on:

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

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

glossary

Annualized Regular Pay

Chevron annualizes your regular pay to determine your coverage amount and contributions, if any, under the Life and Accident Insurance and Long-Term Disability plans.

Your annualized regular pay is calculated as follows, depending on how you're paid:

- If you're paid an annual salary, your annualized regular pay will be your salary amount plus certain shift differentials, if applicable, and your coverage will be based on that amount.

- If you're paid weekly or hourly, your annualized regular pay will be determined by multiplying your base rate of pay by the annual number of weeks or hours in your regular work schedule (as determined by the company), and adding shift differentials, if any. Your coverage will be based on that amount.

Once your annualized regular pay is determined, it will stay the same until your rate of pay changes. This means that your monthly deductions for your coverage will stay the same as long as your pay stays the same, or until you change your level of coverage.

Approved Part-Time Work Schedules

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.

Casual Employee

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

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.

Disability or Total Disability
See the **Disability Defined** chapter of this summary plan description for the definition of a disability or total disability.

Doctor or Licensed Physician
A person who is legally licensed to practice medicine and isn't related to you. A licensed medical practitioner is considered a doctor if:

- He or she is a licensed practitioner of the healing arts in a category specifically favored under the health insurance laws of the state where the treatment is received and he or she is practicing within the scope of his or her license.
- The care and treatment provided by the practitioner is within the scope of his or her license.
- Related to a stable, totally disabled individual, the medical treatment is consistent with guidelines and is of demonstrable medical value.

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.

Gainful Occupation
An occupation that is or can be expected to provide you with an income equal to 70 percent of your predictability annualized regular pay within 12 months of your return to work.

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 HR Service Center 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.

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 in some respects, but doesn’t require that they be eligible for benefits.

Payroll
The system used by Chevron to withhold employment taxes and pay those it classifies as its common-law employees. The term doesn't include any system to pay workers whom Chevron doesn't consider to be 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.

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

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

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

Vocational Rehabilitation and Return-to-Work Assistance Program
A program to assist members in returning to work.

The claims administrator, in its sole discretion, determines eligibility for the Vocational Rehabilitation and Return-to-Work Program. At the claims administrator's sole discretion, the program may include, but is not limited to, any of the following services and benefits:

- Coordination with the company to assist with the member's return to work.
- Adaptive equipment or job accommodations to allow the member to work.
- Vocational evaluation to determine how the member's disability may impact employment options.
- Job placement services.
- Resume preparation.
- Job seeking skills training.
- Education and retraining expenses for a new occupation.