



mental health and substance abuse benefits

**U.S.-payroll employees
summary plan description
effective january 1, 2017**

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This summary plan description (SPD) describes the Mental Health and Substance Abuse Plan sponsored by Chevron.

This document describes the Mental Health and Substance Abuse Plan as of January 1, 2017, that Chevron sponsors for eligible employees. This information constitutes the SPD of the Mental Health and Substance Abuse 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.

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

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

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

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benefit contact information

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

Human Resources Service Center (HR Service Center)

Why contact this administrator

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

COBRA and Continuation Coverage for Chevron Health Plans

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

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

Phone information

- 1-888-825-5247

Benefits Connection Website

- **Benefits Connection** website for personal information and conduct certain transactions, such as changing your address, updating your beneficiaries, view your current enrollments and costs, enroll in Chevron benefits, **enroll in COBRA coverage for health plans**, make benefit changes or make open enrollment elections.
- As an employee, go to **hr2.chevron.com** and click the **Benefits Connection** link.
- 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.

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.

Beacon Health Options

Claims administrator for the Mental Health and Substance Abuse Plan and manages your benefits.

Why contact this administrator

- Ask questions about your plan coverage.
- Locate providers in the network.
- Contact Beacon Health Options for plan notifications or pre-certification requirements for services that require it.
- Get help resolving issues or concerns with your treatment.
- Answer questions about mental health and substance abuse concerns (in potentially life-threatening emergencies, always call 911).

Phone information

- 1-800-847-2438 (inside the U.S.)
- 714-763-2420 (Outside the U.S., call collect)
- 24 hours a day, seven days a week

Website information

- Locate a network provider, check your benefits and coverage, get important documents for your care.
- **www.beaconhealthoptions.com**

Employee Assistance and WorkLife Services (EAP-WorkLife)

Chevron's Employee Assistance and WorkLife Services (EAP-WorkLife) is a confidential consulting service that is staffed with licensed, certified mental health professionals who are familiar with Chevron policies and culture. Services are available to Chevron employees, family members and retirees worldwide.

Why contact this service

- You can use the service to help you resolve a broad range of personal, family and work-related concerns or problems. Advisors can help you clarify the problem and develop a plan to resolve it.
- Advisors can help you locate a network provider in your local area.
- Employees are encouraged to notify EAP-WorkLife before receiving inpatient substance abuse treatment. If you do, the inpatient services may be covered at a higher percentage.

Phone information

- 1-800-860-8205
- 925-842-3333 (CTN 842-3333)

Website information

- Access from the Chevron network only.
- hr.chevron.com/globalprograms/eap/default.aspx

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 Mental Health and Substance Abuse Plan (also referred to as the MHSA Plan) provides confidential support for a wide range of personal issues — from everyday challenges to more serious problems. Beacon Health Options is the claims administrator of the MHSA Plan.

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- The MHSA plan covers medically necessary and appropriate treatment as a result of a diagnosis of a mental illness or substance abuse. It also covers treatment for mental health and substance abuse concerns including services for depression, stress/anxiety, family or relationship issues, personal or work concerns, drug and alcohol recovery, dealing with domestic violence, eating disorders, and others.
- You're automatically covered if you're an eligible employee, even if you are not enrolled in a medical plan to which Chevron contributes. If your dependents are enrolled in a medical plan to which Chevron contributes, they're also automatically covered under this plan.
- Chevron currently pays the full monthly premium for this coverage as part of its contributions toward your medical plan coverage.
- Beacon Health Options is the claims administrator for the plan and helps manage your benefits. Beacon Health Options services include help with:
 - Locating providers in the network.
 - Answering questions about mental health and substance abuse concerns.
 - Answering questions about your plan coverage.
 - Monitoring treatment progress.
 - Resolving problems or concerns you may have with your treatment.
- Chevron's Employee Assistance and WorkLife Services (EAP-WorkLife) is an internal consulting service that is staffed with licensed, certified mental health professionals who are familiar with Chevron policies and culture. EAP-WorkLife can:
 - Provide consultation on a broad range of issues from practical, everyday issues to more complicated personal and work-related concerns.
 - Listen to your concerns and, if you decide you'd like more help, they can help locate a Beacon Health Options network provider in your local area.
- You will receive a higher level of coverage if you use a provider that is in the Beacon Health Options network. The network includes over 7,000 facilities and 49,000 behavioral health clinicians across the U.S. to assist you. The network does not include providers or facilities outside of the U.S.
- To be considered an eligible expense under the plan, certain services require notification to Beacon Health Options. If you do not notify Beacon Health Options when you receive certain services, the service may not be covered, or in some cases you will pay a higher percentage for your care.
- **Employees are encouraged to notify EAP-WorkLife before receiving inpatient substance abuse treatment.** If you do, the inpatient services may be covered at a higher percentage.
- Whether you call Beacon Health Options or EAP-WorkLife, your privacy and that of your dependents will be respected. The nature of your call will be kept confidential, unless there's an immediate threat to life or health.

Mental Health and Substance Abuse Plan (MHSA) is a grandfathered health plan under the Patient Protection and Affordable Care Act.

Chevron Corporation believes the Chevron Corporation Mental Health and Substance Abuse Plan (the MHSA Plan) is a grandfathered health plan under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 1-888-825-5247. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

eligibility

This section provides information about benefit plan eligibility rules for you and your dependents. For more information regarding enrollment procedures, see the **Participation** chapter.

Note for Expatriates in the U.S.: If you are a non-U.S.-payroll expatriate working in the United States, refer to the *Health Benefits for Expatriates in the U.S.* summary plan description for information about the mental health and substance abuse benefits that apply to you.

additional eligibility requirements for this benefit

This section of this summary plan description provides important information about who's generally eligible to participate in Chevron's health benefits. To be eligible to participate in the Mental Health and Substance Abuse Plan (MHSA), you and your dependents must meet all the requirements of an eligible employee and an eligible spouse, domestic partner, child or other dependent as described in this chapter, **and** you and your dependent must *also* satisfy these additional eligibility requirements or restrictions:

- You're automatically enrolled in the Mental Health and Substance Abuse Plan if you're an eligible employee. You're covered by the MHSA Plan even if you are not enrolled in a medical plan offered by Chevron.
- Your dependents must be eligible for and enrolled in a medical plan to which Chevron contributes to participate in the Mental Health and Substance Abuse Plan. Chevron's medical plans generally include the Chevron Medical PPO Plan, the Chevron High Deductible Health Plan, the Chevron High Deductible Health Plan Basic, any of the Chevron Medical HMO plans (if available), or the Global Choice Plan (U.S.-Payroll Expatriates). If your eligible dependents are enrolled in any one of these plans, they are also automatically enrolled in the Mental Health and Substance Abuse Plan (MHSA).
- If your dependent is *not* enrolled in a medical plan to which Chevron contributes, then your dependent cannot participate in the Mental Health and Substance Abuse Plan.
- If you and/or your dependents do not meet the eligibility requirements, then you and your dependents are not eligible to participate in the Mental Health and Substance Abuse Plan (MHSA).

eligible employees

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

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

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

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

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

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

Chevron Human Resources Service Center
P.O. Box 18012
Norfolk, VA 23501
1-888-825-5247

eligible spouse

An eligible spouse is a person to which you are legally married under the law of a state or other jurisdiction where the marriage took place. You can't cover your spouse as a dependent if he or she is any of the following:

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

If both you and your spouse are eligible employees and/or eligible retirees, only one of you can enroll all of your children for coverage.

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

eligible domestic partner

To qualify for benefits available to domestic partners of Chevron employees, you must register your partner with Chevron. To do so, you and your partner must obtain and sign the *Chevron Affidavit of Domestic Partnership (F-6)* form. This form is available through the HR Service Center. The original of the affidavit form must be notarized and sent to the HR Service Center. By signing the affidavit, you certify that you and your partner meet one of the following qualifications:

1. You and your partner are all of the following:
 - At least age 18 and of legal age.
 - Mentally competent to enter into contracts.
 - Jointly responsible for each other's welfare and financial obligations and have lived together for at least six months prior to signing the affidavit.
 - In an intimate, committed relationship of mutual caring that has existed for at least six months prior to the signing of the affidavit and it is expected to continue indefinitely.
 - Not related by blood.
 - Not married to anyone other than each other.
2. You live in California and meet all of the requirements of the California Family Code section 297 definition of a domestic partner, including the requirement to have registered your domestic partner with the Secretary of State's office. For more information, visit the California Domestic Partnership website at www.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. Otherwise, you must wait until the next open enrollment. For information about imputed income and before-tax vs. after-tax contributions for domestic partners, see the **Participation** chapter.

You can't enroll your domestic partner for coverage if he or she is any of the following:

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

If both you and your domestic partner are eligible employees or eligible retirees, only one of you can enroll all of your children for coverage.

eligible children and other dependents

Your dependent child is eligible for coverage if he or she is *all* of the following:

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

Your *other dependent* is eligible for this coverage if he or she is all of the following:

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

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

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

For chronic disabilities, as determined by Chevron's medical plan administrator, you must provide documentation every two years. If the disability is not chronic, Chevron's medical plan administrator will determine how frequently you will need to provide such documentation. For details, contact the HR Service Center.

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

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

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

Qualified Medical Child Support Order (QMCSO)

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

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

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

participation

This section provides important information about participation in the Mental Health and Substance Abuse Plan.

when participation begins

Your participation in the Mental Health and Substance Abuse Plan begins on your first day of work, provided you are eligible. Dependents must be enrolled in a Chevron medical plan to receive Mental Health and Substance Abuse Plan coverage. Dependents begin participation in the Mental Health and Substance Abuse Plan when they begin participation in a medical plan with Chevron.

If you add or drop medical coverage for a dependent during the year, Mental Health and Substance Abuse Plan coverage for that dependent will automatically be added or dropped, too.

when participation ends

Your Mental Health and Substance Abuse Plan participation will end if any one of the following applies:

- You're no longer an eligible employee.
- Chevron Corporation terminates the plan.

Generally, dependent coverage will end when any of the following applies:

- You're no longer an eligible employee.
- Your dependent's coverage under the medical plan ends.
- Your dependent is no longer eligible (for example, you become divorced or a child reaches age 26).

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

What Happens if You Die

See the **If You Die** chapter of this summary plan description for information.

imputed income and before-tax vs. after-tax contributions for domestic partners

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

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

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

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

Before you enroll your domestic partner in Chevron benefits, request and complete the “domestic partner” package that includes important forms and personalized information about benefits enrollment, taxes and beneficiaries. Contact the HR Service Center to speak with a Customer Service Representative.

how much you pay for coverage

Chevron currently pays the full monthly premium for the Mental Health and Substance Abuse Plan coverage. You pay no monthly premiums.

how the plan works

section A

How the plan works depends on which Chevron-sponsored medical plan you choose, if any.

Read this section if:

- You are *not enrolled* in any of Chevron's medical coverage options.
- You are enrolled in the Chevron Medical PPO.
- You are enrolled in the Chevron Global Choice Plan (U.S.-Payroll Expatriates).

Read Section B if:

- You are enrolled in the Chevron High Deductible Health Plan (HDHP).
- You are enrolled in the Chevron High Deductible Health Plan Basic (HDHP Basic)

Read Section C if:

- You are enrolled in a Chevron Medical HMO that is **not** listed under Section D below.

Read Section D if

- You are enrolled in any of these Chevron Medical HMO Plans:
 - Hawaii Medical Service Association (HMSA)
 - Kaiser Hawaii
 - Humana USW (Local 447)
 - Kaiser USW Local 5 \$15 HMO Plan
 - Kaiser USW Local 5 \$500 Deductible HMO Plan

network and out-of-network providers

The plan provides benefits for mental health and substance abuse (MHSA) treatment:

- **If you go to a network provider:**

Generally, the plan pays a higher level of reimbursement for care when you use a provider in the Beacon Health Options network. Network providers charge discounted rates for covered services they provide to plan members and the plan benefits are based on these discounted rates. In addition, you do not have to file a claim form if you use a network provider. Certain services require notification to Beacon Health Options. If you do not notify Beacon Health Options, you may pay a higher percentage for your care. To get a list of providers in your area, call Beacon Health Options or EAP-WorkLife.

- **If you go to an out-of-network provider (also referred to as a non-network provider):**

Generally, the plan pays lower benefits for care when you go to an out-of-network provider and the plan benefits are based on Allowed Charges. For services provided outside the U.S., allowed charges means billed charges. In addition, you typically will be required to pay for the services when you receive them and submit a claim form to be reimbursed. Certain services require notification to Beacon Health Options. If you do not notify Beacon Health Options, you may pay a higher percentage for your care.

If there are no Beacon Health Options providers near your home, Beacon Health Options can help you locate a qualified clinician or facility in your area and review their credentials for you. In cases like these, you may qualify for the network coverage level, even though the provider who treats you or your dependent isn't a member of the Beacon Health Options network.

deductible

There is no deductible for this plan if:

- You are *not* enrolled in any of Chevron's medical coverage options.
- You are enrolled in the Chevron Medical PPO.
- You are enrolled in the Chevron Global Choice Plan (U.S.-Payroll Expatriates).

out-of-pocket maximum feature

The plan pays a percentage of covered charges, and you pay any costs above the amount paid by the plan until you reach the out-of-pocket maximum. Under this feature, after your out-of-pocket costs reach the specified amount for the coverage tier corresponding to your medical plan enrollment in the chart below, the plan pays 100 percent of all covered charges until the end of the calendar year.

If you are not enrolled in a medical plan offered by Chevron, then your annual out-of-pocket maximum amount is the amount shown below for the *You Only* coverage tier. Note that your eligible out-of-pocket Medical PPO plan expenses (or Global Choice Plan expenses, if applicable) will be combined with your eligible out-of-pocket mental health and substance abuse expenses under the MHSA Plan to determine if your out-of-pocket maximum has been reached.

Coverage Tier	Not Enrolled in any Chevron Medical Coverage	Medical PPO or Chevron Global Choice Plan
You Only	\$2,300	\$3,000
You + One Adult	Not applicable	\$6,000
You + Child(ren)	Not applicable	\$6,000
You + Family	Not applicable	\$9,000

Each covered individual has a maximum out-of-pocket amount equal to the *You Only* maximum out-of-pocket amount. For the *You + One Adult*, *You + Child(ren)*, and *You + Family* coverage tiers, there is an overall maximum out-of-pocket amount for all covered participants that corresponds to the coverage category elected. No more than the *You Only* maximum out-of-pocket amount can be applied for any one person to satisfy the overall applicable out-of-pocket maximum.

For example, if you, your spouse/domestic partner and your eligible children are covered under the Medical PPO, you are in the *You + Family* coverage tier. Your annual out-of-pocket maximum is met when the family's accumulation of out-of-pocket costs reach \$9,000, with no more than \$3,000 applied for each family member. Your family could meet the \$9,000 maximum limit with charges of \$3,000 for one member, \$2,200 for a second member, \$1,800 for a third member and \$2,000 for a fourth member.

The following expenses do not count toward the out-of-pocket maximum amount and are not part of the 100 percent coverage you receive after reaching your out-of-pocket maximums:

- Charges in excess of covered charges.
- Charges for services, supplies or treatments that are not covered under the MHSA plan.
- Charges for services, supplies or treatments from a network provider that are in excess of the network provider charges.
- Charges for services, supplies or treatments from an out-of-network provider that are in excess of the allowed charges, except for emergency services.
- Charges resulting from the failure to meet the notification requirements.

what the plan pays – mental health benefits

This section provides information about the network and out-of-network benefits for covered services. In certain situations, to receive the full benefits, you have to follow certain notification procedures. Keep in mind that the plan only pays benefits for covered charges for services, supplies, and treatment that are medically necessary and appropriate, as determined by Beacon Health Options, the claims administrator.

Inpatient Treatment and Alternative Levels of Care

Inpatient treatment includes all 24-hour, medically intensive levels of care, including acute inpatient and detoxification.

Alternative levels of care includes all alternatives to acute inpatient and detoxification, including residential treatment, day treatment, partial hospitalization, structured outpatient programs, and intensive outpatient programs.

Network	<ul style="list-style-type: none">• 90% of network provider charges with notification to Beacon Health Options within three business days of admission.• 60% of network provider charges without notification to Beacon Health Options, or the rate Beacon Health Options has negotiated for not providing notification, if lower.
Out-of-Network	<ul style="list-style-type: none">• 80% of allowed charges with notification to Beacon Health Options within three business days of admission.• 60% of allowed charges without notification to Beacon Health Options.
Non-US Services (Global Choice Plan only)	90% of allowed charges.

Notification to Beacon Health Options

In order to receive the full benefits provided by the MHSA Plan, notification to Beacon Health Options is required. Notification to Beacon Health Options allows them to review your provider's proposed treatment plan for medical necessity and advise your provider how many visits or days of care may be covered.

- If you visit a **network provider**, your provider can notify Beacon Health Options and submit a proposed treatment plan on your behalf.
- If you visit an **out-of-network provider**, you are responsible for notifying Beacon Health Options and coordinating directly with your provider to submit a proposed treatment plan to Beacon Health Options.

You or your provider should periodically check in with Beacon Health Options to ensure that your treatment plan continues to be covered. If the treatment plan is not covered, Beacon Health Options will advise your provider.

Inpatient services must meet medical necessity as determined by Beacon Health Options. Some services require pre-certification (for example, psychological testing and electroconvulsive therapy).

The plan provides coverage for inpatient treatment incurred while confined to a hospital or while being treated under an alternative level of care. Alternative level of care includes an intensive outpatient program or structured outpatient program which operates two to four days per week for at least three hours each day or partial hospitalization program which operates 3-5 days per week for 4-6 hours each day. This includes charges for prescription drugs if provided specifically as part of hospital inpatient or residential treatment center care.

The plan also provides coverage for day treatment which is generally less acute care where the patient is in a day or evening program.

No plan benefits are paid for custodial care.

Outpatient Office Visits

Outpatient office visits include individual, group, family, medication management.

Network	90% of network provider charges after 10% coinsurance (maximum \$25) per visit.
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Out-of-Network	80% of allowed charges.
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Non-US Services (Global Choice Plan only)	90% of allowed charges after 10% coinsurance (maximum \$25) per visit.
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Outpatient services must meet medical necessity as determined by Beacon Health Options. Some services require pre-certification (for example, psychological testing and electroconvulsive therapy).

The plan provides coverage for outpatient office visits for the treatment of mental health problems. Included is treatment for serious conditions, such as depression, stress/anxiety, substance abuse, eating disorders, as well as everyday challenges such as family stress, relationship difficulties and problems at work.

The Mental Health and Substance Abuse Plan doesn't cover prescription drugs for outpatient office visit treatment. If you're prescribed a drug as part of your outpatient treatment, you should check with your prescription drug administrator to find out if it can help pay for the drugs you need; otherwise, you'll be responsible for paying the full cost of prescribed outpatient medication.

Both Beacon Health Options and Chevron's EAP-WorkLife can help you locate a Beacon Health Options network provider in your area.

Emergency Services

Network	90% of network provider charges after 10% coinsurance (\$250 maximum).
Out-of-Network	90% of billed charges after 10% coinsurance (\$250 maximum).
Non-US Services (Global Choice Plan only)	90% of billed charges after 10% coinsurance (\$250 maximum).

If you or a dependent needs emergency care, you should go to the nearest hospital emergency room.

To qualify for plan benefits, emergency care must be required for the immediate diagnosis and treatment of a medical or mental condition that, if not treated immediately, could reasonably be expected to result in severe pain, permanent disability, serious medical complications, loss of life or danger to the patient or others.

Psychological Testing and Electroconvulsive Therapy

Network	<ul style="list-style-type: none">• 90% of network provider charges. Requires notification to Beacon Health Options prior to services being provided.• 60% of network provider charges without notification to Beacon Health Options, or the rate Beacon Health Options has negotiated for not providing notification, if lower.
Out-of-Network	<ul style="list-style-type: none">• 80% of allowed charges. Requires notification to Beacon Health Options prior to services being provided.• 60% of the allowed charges, for an out-of-network provider, without notification to Beacon Health Options.
Non-US Services (Global Choice Plan only)	90% of allowed charges.

Notification to Beacon Health Options

Advance notification to Beacon Health Options is required and services must be medically necessary and appropriate in order to receive the full benefits under the MHSA Plan.

- If you visit a **network provider**, your provider can notify Beacon Health Options and submit a proposed treatment plan on your behalf.
- If you visit an **out-of-network provider**, you are responsible for notifying Beacon Health Options and coordinating directly with your provider to submit a proposed treatment plan to Beacon Health Options.

You or your provider should periodically check in with Beacon Health Options to ensure that your treatment plan continues to be covered. If the treatment plan is not covered, Beacon Health Options will advise your provider.

The plan covers psychological testing and electroconvulsive therapy when used to diagnose a mental health disorder or when provided in conjunction with a diagnosed/covered psychiatric disorder. Psychological testing for learning disabilities is not covered.

what the plan pays – substance abuse benefits

This section provides information about the network and out-of-network benefits for covered services. In certain situations, to receive the full benefits, you have to follow certain notification procedures. Keep in mind that the plan only pays benefits for covered charges for services, supplies, and treatment that are medically necessary and appropriate, as determined by Beacon Health Options, the claims administrator.

Inpatient Treatment and Alternative Levels of Care

Inpatient treatment includes all 24-hour, medically intensive levels of care, including acute inpatient and detoxification.

Alternative levels of care includes all alternatives to acute inpatient and detoxification, including residential treatment, day treatment, partial hospitalization, structured outpatient programs, and intensive outpatient programs.

Network

Employees:

- **100%** of network provider charges for the first \$5,000 if you voluntarily notify EAP-WorkLife within three business days of admission. After the first \$5,000, **90%** of network provider charges. The 100% of network provider charges for the first \$5,000 benefit is paid once per person, per lifetime.
- If you do not notify EAP-WorkLife, but you notify Beacon Health Options within three business days of admission, **90%** of network provider charges.

Dependents:

- **90%** of network provider charges with notification to Beacon Health Options within three business days of admission.

Employees and Dependents:

- If you *do not* meet any of the notification requirements within three business days of admission, **60%** of network provider charges, or the rate Beacon Health Options has negotiated for not providing notification, if lower.
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Out-of-Network

Employees and Dependents:

- **80%** of allowed charges with notification to Beacon Health Options within three business days of admission.

Employees and Dependents:

- **60%** of allowed charges if you do not notify Beacon Health Options within three business days of admission.
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Inpatient Treatment and Alternative Levels of Care (continued)

Non-US Services

(Global Choice Plan only)

Employees:

- **100%** of allowed charges for the first \$5,000 if you voluntarily notify EAP-WorkLife within three business days of admission. After the first \$5,000, **90%** of allowed charges. The 100% of allowed charges for the first \$5,000 benefit is paid once per person, per lifetime.
- **90%** of allowed charges without notification to EAP-WorkLife within three business days of admission.

Dependents:

- **90%** of allowed charges.
-

Notification to Beacon Health Options

In order to receive the full benefits provided by the MHSA Plan, notification to Beacon Health Options is required. Notification to Beacon Health Options allows Beacon to review your provider's proposed treatment plan for medical necessity and advise your provider how many visits or days of care may be covered.

- If you visit a **network provider**, your provider can notify Beacon Health Options and submit a proposed treatment plan on your behalf.
- If you visit an **out-of-network provider**, you are responsible for notifying Beacon Health Options and coordinating directly with your provider to submit a proposed treatment plan to Beacon Health Options.

You or your provider should periodically check in with Beacon Health Options to ensure that your treatment plan continues to be covered. If the treatment plan is not covered, Beacon Health Options will advise your provider.

Inpatient services must meet medical necessity as determined by Beacon Health Options. Some services require pre-certification (for example, psychological testing and electroconvulsive therapy).

The plan provides coverage for inpatient treatment incurred while confined to a hospital or while being treated under an alternative level of care. Alternative level of care includes an intensive outpatient program or structured outpatient program which operates two to four days per week for at least three hours each day or partial hospitalization program which operates 3-5 days per week for 4-6 hours each day. This includes charges for prescription drugs if provided specifically as part of hospital inpatient or residential treatment center care.

The plan also provides coverage for day treatment which is generally less acute care where the patient is in a day or evening program.

No plan benefits are paid for custodial care.

Office Visits

Office visits include individual, group, family, medication management.

Network	90% of network provider charges after 10% coinsurance (maximum \$25) per visit.
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Out-of-Network	80% of allowed charges.
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Non-US Services (Global Choice Plan only)	90% of allowed charges after 10% coinsurance (maximum \$25) per visit.
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Outpatient services must meet medical necessity as determined by Beacon Health Options. Some services require pre-certification (for example, psychological testing and electroconvulsive therapy).

The plan provides coverage for outpatient office visits for the treatment of substance abuse problems.

The Mental Health and Substance Abuse Plan doesn't cover prescription drugs for outpatient office visit treatment. If you're prescribed a drug as part of your outpatient treatment, you should check with your prescription drug administrator to find out if it can help pay for the drugs you need; otherwise, you'll be responsible for paying the full cost of prescribed outpatient medication.

Both Beacon Health Options and Chevron's EAP-WorkLife can help you locate a Beacon Health Options network provider in your area.

Emergency Services

Network	90% of network provider charges after 10% coinsurance (\$250 maximum).
----------------	--

Out-of-Network	90% of billed charges after 10% coinsurance (\$250 maximum).
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Non-US Services (Global Choice Plan only)	90% of billed charges after 10% coinsurance (\$250 maximum).
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If you or a dependent needs emergency care, you should go to the nearest hospital emergency room.

To qualify for plan benefits, emergency care must be required for the immediate diagnosis and treatment of a medical or mental condition that, if not treated immediately, could reasonably be expected to result in severe pain, permanent disability, serious medical complications, loss of life or danger to the patient or others.

how the plan works

section B

How the plan works depends on which Chevron-sponsored medical plan you choose, if any.

Read this section if:

- You are enrolled in the Chevron High Deductible Health Plan (HDHP).
 - You are enrolled in the Chevron High Deductible Health Plan Basic (HDHP Basic)
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Read Section A if:

- You are **not** enrolled in a Chevron-sponsored medical plan.
- You are enrolled in the Chevron Medical PPO.
- You are enrolled in the Chevron Global Choice Plan (U.S.-Payroll Expatriates).

Read Section C if:

- You are enrolled in a Chevron Medical HMO that is **not** listed under Section D below.

Read Section D if

- You are enrolled in any of these Chevron Medical HMO Plans:
 - Hawaii Medical Service Association (HMSA)
 - Kaiser Hawaii
 - Humana USW (Local 447)
 - Kaiser USW Local 5 \$15 HMO Plan
 - Kaiser USW Local 5 \$500 Deductible HMO Plan

network and out-of-network providers

The plan provides benefits for mental health and substance abuse (MHSA) treatment:

- **If you go to a network provider:**
Generally, the plan pays a higher level of reimbursement for care when you use a provider in the Beacon Health Options network. Network providers charge discounted rates for covered services they provide to plan members and the plan benefits are based on these discounted rates. In addition, you do not have to file a claim form if you use a network provider. Certain services require notification to Beacon Health Options. If you do not notify Beacon Health Options, you may pay a higher percentage for your care. To get a list of providers in your area, call Beacon Health Options or EAP WorkLife.
- **If you go to an out-of-network provider (also referred to as a non-network provider):**
Generally, the plan pays lower benefits for care when you go to an out-of-network provider and the plan benefits are based on allowed charges. For services provided outside the U.S., allowed charges means billed charges. In addition, you typically will be required to pay for the services when you receive them and submit a claim form to be reimbursed. Certain services require notification to Beacon Health Options. If you do not notify Beacon Health Options, you may pay a higher percentage for your care.

If there are no Beacon Health Options providers near your home, Beacon Health Options can help locate a qualified clinician or facility in your area and review their credentials for you. In cases like these, you may qualify for the network coverage level, even though the provider who treats you or your dependent isn't a member of the Beacon Health Options network.

deductible

There is a deductible for this plan. If you are enrolled in the Chevron High Deductible Health Plan (HDHP) or the Chevron High Deductible Health Plan Basic (HDHP Basic), there is a combined deductible for medical, prescription drugs (both retail and mail-order), and mental health and substance abuse to satisfy. You must satisfy your combined deductible before the MHSA Plan shares the cost of mental health or substance abuse services. This means you must pay out of pocket for covered mental health and substance abuse services until you reach the combined deductible.

Annual Deductible Medical, Prescription Drug, Mental Health and Substance Abuse Combined		
Coverage Tier	High Deductible Health Plan (HDHP)	High Deductible Health Plan Basic (HDHP Basic)
You Only	\$2,650	\$5,000
You + One Adult	\$5,300	\$10,000
You + Child(ren)	\$5,300	\$10,000
You + Family	\$5,300	\$10,000

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

For example, if you, your spouse/domestic partner and your eligible children are covered under the HDHP, you are in the *You + Family* coverage tier. Your annual deductible is met when the family's accumulation of covered services and supplies reaches \$5,300, with no more than \$2,650 applied for each family member. Your family could meet the \$5,300 annual deductible with charges of \$2,650 for one member, \$1,200 for a second member, \$1,400 for a third member and \$50 for a fourth member.

out-of-pocket maximum feature

The plan pays a percentage of covered charges, and you pay any costs above the amount paid by the plan until you reach the out-of-pocket maximum. Under this feature, after your out-of-pocket costs reach the specified amount for the coverage tier corresponding to your medical plan enrollment in the chart below, the plan pays 100 percent of all covered charges until the end of the calendar year.

If you are enrolled in the Chevron High Deductible Health Plan (HDHP) or the Chevron High Deductible Health Plan Basic (HDHP Basic) there is a combined out-of-pocket maximum for medical, prescription drugs (both retail and mail order), and mental health and substance abuse services.

Out-of-Pocket Maximum Medical, Prescription Drug, Mental Health and Substance Abuse Combined		
Coverage Tier	High Deductible Health Plan (HDHP)	High Deductible Health Plan Basic (HDHP Basic)
You Only	\$5,000	\$6,550
You + One Adult	\$9,000	\$13,100
You + Child(ren)	\$9,000	\$13,100
You + Family	\$10,000	\$13,100

Each covered individual has a maximum out-of-pocket amount equal to the *You Only* maximum out-of-pocket amount. For the *You + One Adult*, *You + Child(ren)*, and *You + Family* coverage tiers, there is an overall maximum out-of-pocket amount for all covered participants that corresponds to the coverage category elected. No more than the *You Only* maximum out-of-pocket amount can be applied for any one person to satisfy the overall applicable out-of-pocket maximum.

For example, if you, your spouse/domestic partner and your eligible children are covered under the HDHP, you are in the *You + Family* coverage tier. Your annual out-of-pocket maximum is met when the family's accumulation of out-of-pocket costs reaches \$10,000, with no more than \$5,000 applied for each family member. Your family could meet the \$10,000 maximum limit with charges of \$5,000 for one member, \$3,500 for a second member, \$1,000 for a third member and \$500 for a fourth member.

The following expenses do not count toward the out-of-pocket maximum amount and are not part of the 100 percent coverage you receive after reaching your out-of-pocket maximums:

- Charges in excess of covered charges.
- Charges for services, supplies or treatments that are not covered under the MHSA plan.
- Charges for services, supplies or treatments from a Network Provider that are in excess of the Network Provider Charges.
- Charges for services, supplies or treatments from an Out-of-Network Provider that are in excess of the Allowed Charges, except for emergency services.
- Charges resulting from the failure to meet the notification requirements.
- Charges that do not count toward the out-of-pocket maximum under the Chevron High Deductible Health Plan or the Chevron High Deductible Health Plan Basic.

what the plan pays – mental health benefits

This section provides information about the network and out-of-network benefits for covered services. In certain situations, to receive the full benefits, you have to follow certain notification procedures. Keep in mind that the plan only pays benefits for covered charges for services, supplies, and treatment that are medically necessary and appropriate, as determined by Beacon Health Options, the claims administrator.

Inpatient Treatment and Alternative Levels of Care

Inpatient treatment includes all 24-hour, medically intensive levels of care, including acute inpatient and detoxification.

Alternative levels of care includes all alternatives to acute inpatient and detoxification, including residential treatment, day treatment, partial hospitalization, structured outpatient programs, and intensive outpatient programs.

- | | |
|----------------|---|
| Network | <ul style="list-style-type: none">• After HDHP or HDHP Basic annual deductible is met, 90% of network provider charges with notification to Beacon Health Options within three business days of admission.• After HDHP or HDHP Basic annual deductible is met, 60% of network provider charges without notification to Beacon Health Options, or the rate Beacon Health Options has negotiated for not providing notification, if lower. |
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| Out-of-Network | <ul style="list-style-type: none">• After HDHP or HDHP Basic annual deductible is met, 80% of allowed charges with notification to Beacon Health Options within three business days of admission.• After HDHP or HDHP Basic annual deductible is met, 60% of allowed charges without notification to Beacon Health Options. |
|-----------------------|--|
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Notification to Beacon Health Options

In order to receive the full benefits provided by the MHSA Plan, notification to Beacon Health Options is required. Notification to Beacon Health Options allows Beacon Health Options to review your provider's proposed treatment plan for medical necessity and advise your provider how many visits or days of care may be covered.

- If you visit a **network provider**, your provider can notify Beacon Health Options and submit a proposed treatment plan on your behalf.
- If you visit an **out-of-network provider**, you are responsible for notifying Beacon Health Options and coordinating directly with your provider to submit a proposed treatment plan to Beacon Health Options.

You or your provider should periodically check in with Beacon Health Options to ensure that your treatment plan continues to be covered. If the treatment plan is not covered, Beacon Health Options will advise your provider.

Inpatient services must meet medical necessity as determined by Beacon Health Options. Some services require pre-certification (for example, psychological testing and electroconvulsive therapy).

The plan provides coverage for inpatient treatment incurred while confined to a hospital or while being treated under an alternative level of care. Alternative level of care includes an intensive outpatient program or structured outpatient program which operates two to four days per week for at least three hours each day or partial hospitalization program which operates 3-5 days per week for 4-6 hours each day. This includes charges for prescription drugs if provided specifically as part of hospital inpatient or residential treatment center care.

The plan also provides coverage for day treatment which is generally less acute care where the patient is in a day or evening program

No plan benefits are paid for custodial care.

Outpatient Office Visits

Outpatient office visits include individual, group, family, medication management.

Network	After HDHP or HDHP Basic annual deductible is met, 90% of network provider charges after 10% coinsurance (maximum \$25) per visit.
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Out-of-Network	After HDHP or HDHP Basic annual deductible is met, 80% of allowed charges.
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Outpatient services must meet medical necessity as determined by Beacon Health Options. Some services require pre-certification (for example, psychological testing and electroconvulsive therapy).

The plan provides coverage for outpatient office visits for the treatment of mental health problems. Included is treatment for serious conditions, such as depression, stress/anxiety, substance abuse, eating disorders, as well as everyday challenges such as family stress, relationship difficulties and problems at work.

The Mental Health and Substance Abuse Plan doesn't cover prescription drugs for outpatient office visit treatment. If you're prescribed a drug as part of your outpatient treatment, you should check with your prescription drug administrator to find out if it can help pay for the drugs you need; otherwise, you'll be responsible for paying the full cost of prescribed outpatient medication.

Both Beacon Health Options and Chevron's EAP-WorkLife can help you locate a Beacon Health Options network provider in your area.

Emergency Services

Network	After HDHP or HDHP Basic annual deductible is met, 90% of network provider charges after 10% coinsurance (maximum \$250).
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Out-of-Network	After HDHP or HDHP Basic annual deductible is met, 90% of billed charges after 10% coinsurance (maximum \$250).
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If you or a dependent needs emergency care, you should go to the nearest hospital emergency room.

To qualify for plan benefits, emergency care must be required for the immediate diagnosis and treatment of a medical or mental condition that, if not treated immediately, could reasonably be expected to result in severe pain, permanent disability, serious medical complications, loss of life or danger to the patient or others.

Psychological Testing and Electroconvulsive Therapy

Network

- After HDHP or HDHP Basic annual deductible is met, **90%** of network provider charges. Requires notification to Beacon Health Options prior to services being provided.
- After HDHP or HDHP Basic annual deductible is met, **60%** of network provider charges without notification to Beacon Health Options, *or* the rate Beacon Health Options has negotiated for not providing notification, if lower.

Out-of-Network

- After HDHP or HDHP Basic annual deductible is met, **80%** of allowed charges. Requires notification to Beacon Health Options prior to services being provided.
- After HDHP or HDHP Basic annual deductible is met, **60%** of allowed charges without notification to Beacon Health Options.

Notification to Beacon Health Options

Advance notification to Beacon Health Options is required and services must be medically necessary and appropriate in order to receive the full benefits under the MHSA Plan.

- If you visit a **network provider**, your provider can notify Beacon Health Options and submit a proposed treatment plan on your behalf.
- If you visit an **out-of-network provider**, you are responsible for notifying Beacon Health Options and coordinating directly with your provider to submit a proposed treatment plan to Beacon Health Options.

You or your provider should periodically check in with Beacon Health Options to ensure that your treatment plan continues to be covered. If the treatment plan is not covered, Beacon Health Options will advise your provider.

The plan covers psychological testing and electroconvulsive therapy when used to diagnose a mental health disorder or when provided in conjunction with a diagnosed/covered psychiatric disorder. Psychological testing for learning disabilities is not covered.

what the plan pays – substance abuse benefits

This section provides information about the network and out-of-network benefits for covered services. In certain situations, to receive the full benefits, you have to follow certain notification procedures. Keep in mind that the plan only pays benefits for covered charges for services, supplies, and treatment that are medically necessary and appropriate, as determined by Beacon Health Options, the claims administrator.

Inpatient Treatment and Alternate Levels of Care

Inpatient treatment includes all 24-hour, medically intensive levels of care, including acute inpatient and detoxification.

Alternative levels of care include all alternatives to acute inpatient and detoxification, including residential treatment, day treatment, partial hospitalization, structured outpatient programs, and intensive outpatient programs.

After HDHP or HDHP Basic annual deductible is met ...

Employees:

- **100%** of network provider charges for the first \$5,000 if you voluntarily notify EAP-WorkLife within three business days of admission. After the first \$5,000, **90%** of network provider charges. The 100% of network provider charges for the first \$5,000 benefit is paid once per person per lifetime.

Network

- If you do not notify EAP-WorkLife but you notify Beacon Health Options within three business days of admission, **90%** of network provider charges.

Dependents:

- **90%** of network provider charges with notification to Beacon Health Options within three business days of admission.

Employees and Dependents:

- If you *do not* meet any of the notification requirements within three business days of admission, **60%** of network provider charges, or the rate Beacon Health Options has negotiated for not providing notification, if lower.
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Inpatient Treatment and Alternate Levels of Care (continued)

After HDHP or HDHP Basic annual deductible is met ...

Employees and Dependents:

Out-of-Network

- **80%** of allowed charges if you notify Beacon Health Options within three business days of admission.

Employees and Dependents:

- **60%** of allowed charges if you don't notify Beacon Health Options within three business days of admission.
-

Notification to Beacon Health Options

In order to receive the full benefits provided by the MHSA Plan, notification to Beacon Health Options is required. Notification to Beacon Health Options allows Beacon Health Options to review your provider's proposed treatment plan for medical necessity and advise your provider how many visits or days of care may be covered.

- If you visit a **network provider**, your provider can notify Beacon Health Options and submit a proposed treatment plan on your behalf.
- If you visit an **out-of-network provider**, you are responsible for notifying Beacon Health Options and coordinating directly with your provider to submit a proposed treatment plan to Beacon Health Options.

You or your provider should periodically check in with Beacon Health Options to ensure that your treatment plan continues to be covered. If the treatment plan is not covered, Beacon Health Options will advise your provider.

Inpatient services must meet medical necessity as determined by Beacon Health Options. Some services require pre-certification (for example, psychological testing and electroconvulsive therapy).

The plan provides coverage for inpatient treatment incurred while confined to a hospital or while being treated under an alternative level of care. Alternative level of care includes an intensive outpatient program or structured outpatient program which operates two to four days per week for at least three hours each day or partial hospitalization program which operates 3-5 days per week for 4-6 hours each day. This includes charges for prescription drugs if provided specifically as part of hospital inpatient or residential treatment center care.

The plan also provides coverage for day treatment which is generally less acute care where the patient is in a day or evening program

No plan benefits are paid for custodial care.

Office Visits

Office Visits include individual, group, family, medication management.

Network After HDHP or HDHP Basic annual deductible is met, **90%** of network provider charges after **10%** coinsurance (maximum \$25) per visit.

Out-of-Network After HDHP or HDHP Basic annual deductible is met, **80%** of allowed charges.

Outpatient services must meet medical necessity as determined by Beacon Health Options. Some services require pre-certification (for example, psychological testing and electroconvulsive therapy).

The plan provides coverage for outpatient office visits for the treatment of substance abuse problems.

The Mental Health and Substance Abuse Plan doesn't cover prescription drugs for outpatient office visit treatment. If you're prescribed a drug as part of your outpatient treatment, you should check with your prescription drug administrator to find out if it can help pay for the drugs you need; otherwise, you'll be responsible for paying the full cost of prescribed outpatient medication.

Both Beacon Health Options and Chevron's EAP-WorkLife can help you locate a Beacon Health Options network provider in your area.

Emergency Services

Network After HDHP or HDHP Basic annual deductible is met, **90%** of network provider charges after **10%** coinsurance (**\$250** maximum).

Out-of-Network After HDHP or HDHP Basic annual deductible is met, **90%** of billed charges after **10%** coinsurance (**\$250** maximum).

If you or a dependent needs emergency care, you should go to the nearest hospital emergency room.

To qualify for plan benefits, emergency care must be required for the immediate diagnosis and treatment of a medical or mental condition that, if not treated immediately, could reasonably be expected to result in severe pain, permanent disability, serious medical complications, loss of life or danger to the patient or others.

how the plan works

section C

How the plan works depends on which Chevron-sponsored medical plan you choose, if any. Read this section if you are enrolled in a Chevron Medical HMO that is **not** listed under Section D below.

Read Section A if:

- You are **not** enrolled in a Chevron-sponsored medical plan.
- You are enrolled in the Chevron Medical PPO.
- You are enrolled in the Chevron Global Choice Plan (U.S.-Payroll Expatriates).

Read Section B if:

- You are enrolled in the Chevron High Deductible Health Plan (HDHP).
- You are enrolled in the Chevron High Deductible Health Plan Basic (HDHP Basic)

Read Section D if

- You are enrolled in any of these Chevron Medical HMO Plans:
 - Hawaii Medical Service Association (HMSA)
 - Kaiser Hawaii
 - Humana USW (Local 447)
 - Kaiser USW Local 5 \$15 HMO Plan
 - Kaiser USW Local 5 \$500 Deductible HMO Plan

overview

The plan pays benefits for mental health and substance abuse (MHSA) treatment **only** when you use a provider in the Beacon Health Options network. Network providers charge discounted rates for covered services they provide to plan members and the plan benefits are based on these discounted rates. In addition, you do not have to file a claim form when you use a network provider.

The plan pays benefits for MHSA services when you go to an out-of-network provider (also referred to as a non-network provider) only for emergency services. If you use an out-of-network provider for non-emergency care, the services are not covered.

Certain services require notification to Beacon Health Options. If you do not notify Beacon Health Options, you may pay a higher percentage for your care. To get a list of providers in your area, call Beacon Health Options or EAP-WorkLife.

If there are no Beacon Health Options providers near your home, Beacon Health Options can help locate a qualified clinician or facility in your area and review their credentials for you. In cases like these, you may qualify for the network coverage level, even though the provider who treats you or your dependent isn't a member of the Beacon Health Options network.

deductible

There is no deductible for this plan if you are enrolled in a Chevron HMO **other than** the Hawaii Medical Service Association (HMSA), Kaiser Hawaii, Humana USW (Local 447), Kaiser USW Local 5 \$15 HMO Plan, Kaiser USW Local 5 \$500 Deductible HMO Plan.

out-of-pocket maximum feature

The plan pays a percentage of covered charges for the care you need, and you pay any costs above the amount paid by the plan until you reach the out-of-pocket maximum.

Under this feature, after your out-of-pocket costs reach the out-of-pocket maximum in effect for you, the plan pays 100 percent of all covered charges until the end of the calendar year. Note that your eligible out-of-pocket Chevron-sponsored HMO expenses will be combined with your eligible out-of-pocket mental health and substance abuse expenses under the MHSA plan to determine if your out-of-pocket maximum has been reached.

The out-of-pocket maximum in effect for you during a calendar year is the lowest out-of-pocket maximum amount under all the Chevron-sponsored HMOs covered by this Section C. In 2017 the out-of-pocket amount is \$2,500 per individual and \$5,000 per family.

The following expenses do not count toward the out-of-pocket maximum amount and are not part of the 100 percent coverage you receive after reaching your out-of-pocket maximums:

- Charges in excess of covered charges.
- Charges for services, supplies or treatments that are not covered under the MHSA plan.
- Charges for services, supplies or treatments from a network provider that are in excess of the network provider charges.
- Charges resulting from the failure to meet the MHSA plan's notification requirements.

Tracking Out-of-Pocket Expenses

Out of pocket expenses will need to be tracked if you're enrolled in a Medical HMO and using mental health or substance abuse benefits under this plan. For claims submitted to Beacon Health Options, Beacon Health Options will track your eligible mental health and substance abuse out-of-pocket expenses but HMO plans are not able to exchange medical out of pocket amounts with Beacon Health Options. When you've reached the annual out of pocket maximum under your HMO, you'll need to inform Beacon Health Options and provide proof by submitting the explanation of benefits received from your Medical HMO.

what the plan pays – mental health benefits

This section provides information about the network and out-of-network benefits for covered services. In certain situations, to receive the full benefits, you have to follow certain notification procedures. Keep in mind that the plan only pays benefits for covered charges for services, supplies, and treatment that are medically necessary and appropriate, as determined by Beacon Health Options, the claims administrator.

Inpatient Treatment and Alternative Levels of Care

Inpatient treatment includes all 24-hour, medically intensive levels of care, including acute inpatient and detoxification.

Alternative levels of care include all alternatives to acute inpatient and detoxification, including residential treatment, day treatment, partial hospitalization, structured outpatient programs, and intensive outpatient programs.

- | | |
|----------------|---|
| Network | <ul style="list-style-type: none">• 100% of network provider charges after a \$250 copayment per admission. Requires notification to Beacon Health Options within three business days of admission.• 60% of network provider charges without notification to Beacon Health Options, or the rate Beacon Health Options has negotiated for not providing notification, if lower. |
|----------------|---|

Out-of-Network Not covered.

Notification to Beacon Health Options

In order to receive the full benefits provided by the MHSA Plan, notification to Beacon Health Options is required. Notification to Beacon Health Options allows Beacon Health Options to review your provider's proposed treatment plan for medical necessity and advise your provider how many visits or days of care may be covered. When you visit a **network provider**, your provider can notify Beacon Health Options and submit a proposed treatment plan on your behalf. You or your provider should periodically check in with Beacon Health Options to ensure that your treatment plan continues to be covered. If the treatment plan is not covered, Beacon Health Options will advise your provider.

Inpatient services must meet medical necessity as determined by Beacon Health Options. Some services require pre-certification (for example, psychological testing and electroconvulsive therapy).

The plan provides coverage for inpatient treatment incurred while confined to a hospital or while being treated under an alternative level of care. Alternative level of care includes an intensive outpatient program or structured outpatient program which operates two to four days per week for at least three hours each day or partial hospitalization program which operates 3-5 days per week for 4-6 hours each day. This includes charges for prescription drugs if provided specifically as part of hospital inpatient or residential treatment center care.

The plan also provides coverage for day treatment which is generally less acute care where the patient is in a day or evening program

No plan benefits are paid for custodial care.

Outpatient Office Visits

Outpatient office visits includes individual, group, family, medication management.

Network **100%** of network provider charges after a \$14 copayment per visit.

Out-of-Network Not covered.

Outpatient services must meet medical necessity as determined by Beacon Health Options. Some services require pre-certification (for example, psychological testing and electroconvulsive therapy).

The plan provides coverage for outpatient office visits for the treatment of mental health problems. Included is treatment for serious conditions, such as depression, stress/anxiety, substance abuse, eating disorders, as well as everyday challenges such as family stress, relationship difficulties and problems at work.

The Mental Health and Substance Abuse Plan doesn't cover prescription drugs for outpatient office visit treatment. If you're prescribed a drug as part of your outpatient treatment, you should check with your Medical HMO to find out if it can help pay for the drugs you need; otherwise, you'll be responsible for paying the full cost of prescribed outpatient medication.

Both Beacon Health Options and Chevron's EAP-WorkLife can help you locate a Beacon Health Options network provider in your area.

Emergency Services

Network **100%** of network provider charges after a \$100 copayment per visit.

Out-of-Network **100%** of billed charges after a \$100 copayment per visit.

If you or a dependent needs emergency care, you should go to the nearest hospital emergency room.

To qualify for plan benefits, emergency care must be required for the immediate diagnosis and treatment of a medical or mental condition that, if not treated immediately, could reasonably be expected to result in severe pain, permanent disability, serious medical complications, loss of life or danger to the patient or others.

Psychological Testing and Electroconvulsive Therapy

- **100%** of network provider charges after a \$14 copayment per visit. Requires notification to Beacon Health Options prior to services being provided.
- Network**
- **60%** of network provider charges without notification to Beacon Health Options, or the rate Beacon Health Options has negotiated for not providing notification, if lower.
-

Out-of-Network Not covered

Notification to Beacon Health Options

Advance notification to Beacon Health Options is required and services must be medically necessary and appropriate in order to receive the full benefits under the MHSA Plan. When you visit a **network provider**, your provider can notify Beacon Health Options and submit a proposed treatment plan on your behalf. You or your provider should periodically check in with Beacon Health Options to ensure that your treatment plan continues to be covered. If the treatment plan is not covered, Beacon Health Options will advise your provider.

what the plan pays – substance abuse benefits

This section provides information about the network and out-of-network benefits for covered services. In certain situations, to receive the full benefits, you have to follow certain notification procedures. Keep in mind that the plan only pays benefits for covered charges for services, supplies, and treatment that are medically necessary and appropriate, as determined by Beacon Health Options, the claims administrator.

Inpatient Treatment and Alternative Levels of Care

Inpatient treatment includes all 24-hour, medically intensive levels of care, including acute inpatient and detoxification.

Alternative levels of care includes all alternatives to acute inpatient and detoxification, including residential treatment, day treatment, partial hospitalization, structured outpatient programs, and intensive outpatient programs.

Network

- **100%** of network provider charges after a \$250 copayment per admission. Requires notification to Beacon Health Options within three business days of admission.
- **60%** of network provider charges after a \$250 copayment per admission without notification.

Out-of-Network Not covered.

Notification to Beacon Health Options

In order to receive the full benefits provided by the MHSA Plan, notification to Beacon Health Options is required. Notification to Beacon Health Options allows Beacon Health Options to review your provider's proposed treatment plan for medical necessity and advise your provider how many visits or days of care may be covered. When you visit a **network provider**, your provider can notify Beacon Health Options and submit a proposed treatment plan on your behalf. You or your provider should periodically check in with Beacon Health Options to ensure that your treatment plan continues to be covered. If the treatment plan is not covered, Beacon Health Options will advise your provider.

Inpatient services must meet medical necessity as determined by Beacon Health Options. Some services require pre-certification (for example, psychological testing).

The plan provides coverage for inpatient treatment incurred while confined to a hospital or while being treated under an alternative level of care. Alternative level of care includes an intensive outpatient program or structured outpatient program which operates two to four days per week for at least three hours each day or partial hospitalization program which operates 3-5 days per week for 4-6 hours each day. This includes charges for prescription drugs if provided specifically as part of hospital inpatient or residential treatment center care.

The plan also provides coverage for day treatment which is generally less acute care where the patient is in a day or evening program.

No plan benefits are paid for custodial care.

Office Visits

Office visits include individual, group, family, medication management.

Network **100%** of network provider charges after a \$14 copayment per visit.

Out-of-Network Not covered.

Outpatient services must meet medical necessity as determined by Beacon Health Options. Some services require pre-certification (for example, psychological testing and electroconvulsive therapy).

The plan provides coverage for outpatient office visits for the treatment of substance abuse problems.

The Mental Health and Substance Abuse Plan doesn't cover prescription drugs for outpatient office visit treatment. If you're prescribed a drug as part of your outpatient treatment, you should check with your Medical HMO to find out if it can help pay for the drugs you need; otherwise, you'll be responsible for paying the full cost of prescribed outpatient medication.

Both Beacon Health Options and Chevron's EAP-WorkLife can help you locate a Beacon Health Options network provider in your area.

Emergency Services

Network **100%** of network provider charges after a \$100 copayment per visit.

Out-of-Network **100%** of billed charges after a \$100 copayment per visit.

If you or a dependent needs emergency care, you should go to the nearest hospital emergency room.

To qualify for plan benefits, emergency care must be required for the immediate diagnosis and treatment of a medical or mental condition that, if not treated immediately, could reasonably be expected to result in severe pain, permanent disability, serious medical complications, loss of life or danger to the patient or others.

how the plan works

section D

How the plan works depends on which Chevron-sponsored medical plan you choose, if any. Read this section if you are enrolled in any of these Chevron Medical HMO Plans:

- Hawaii Medical Service Association (HMSA)
- Kaiser Hawaii
- Humana USW (Local 447)
- Kaiser USW Local 5 \$15 HMO Plan
- Kaiser USW Local 5 \$500 Deductible HMO Plan

Read Section A if:

- You are **not** enrolled in a Chevron-sponsored medical plan.
- You are enrolled in the Chevron Medical PPO.
- You are enrolled in the Chevron Global Choice Plan (U.S.-Payroll Expatriates).

Read Section B if:

- You are enrolled in the Chevron High Deductible Health Plan (HDHP).
- You are enrolled in the Chevron High Deductible Health Plan Basic (HDHP Basic)

Read Section C if

- You are enrolled in a Chevron Medical HMO that is **not** listed under Section D below.

overview

The plan pays benefits for mental health and substance abuse (MHSA) treatment **only** when you use a provider in the Beacon Health Options network. Network providers charge discounted rates for covered services they provide to plan members and the plan benefits are based on these discounted rates. In addition, you do not have to file a claim form when you use a network provider.

The plan pays benefits for MHSA services when you go to an out-of-network provider (also referred to as a non-network provider) only for emergency services. If you use an out-of-network provider for non-emergency care, the services are not covered.

Certain services require notification to Beacon Health Options. If you do not notify Beacon Health Options you may pay a higher percentage for your care. To get a list of providers in your area, call Beacon Health Options or EAP-WorkLife.

If there are no Beacon Health Options providers near your home, Beacon Health Options can help locate a qualified clinician or facility in your area and review their credentials for you. In cases like these, you may qualify for the network coverage level, even though the provider who treats you or your dependent isn't a member of the Beacon Health Options network.

deductible

There is no deductible for this plan if you are enrolled in any of these Chevron Medical HMO Plans:

- Hawaii Medical Service Association (HMSA)
- Kaiser Hawaii
- Humana USW (Local 447)
- Kaiser USW Local 5 \$15 HMO Plan
- Kaiser USW Local 5 \$500 Deductible HMO Plan

out-of-pocket maximum feature

The plan pays a percentage of covered charges for the care you need, and you pay any costs above the amount paid by the plan until you reach the out-of-pocket maximum.

Under this feature, after your out-of-pocket costs reach the out-of-pocket maximum in effect for you, the plan pays 100 percent of all covered charges until the end of the calendar year. Note that your eligible out-of-pocket Chevron-sponsored HMO expenses will be combined with your eligible out-of-pocket mental health and substance abuse expenses under the MHSA plan to determine if your out-of-pocket maximum has been reached.

The out-of-pocket maximum in effect for you during a calendar year is the lowest out-of-pocket maximum amount under all the Chevron-sponsored HMOs noted above that are covered by this Section D.

The following expenses do not count toward the out-of-pocket maximum amount and are not part of the 100 percent coverage you receive after reaching your out-of-pocket maximums:

- Charges in excess of covered charges.
- Charges for services, supplies or treatments that are not covered under the MHSA plan.
- Charges for services, supplies or treatments from a network provider that are in excess of the network provider charges.
- Charges resulting from the failure to meet the MHSA plan's notification requirements.

Tracking Out-of-Pocket Expenses

Out of pocket expenses will need to be tracked if you're enrolled in a Medical HMO and using mental health or substance abuse benefits under this plan. For claims submitted to Beacon Health Options, Beacon Health Options will track your eligible mental health and substance abuse out-of-pocket expenses but HMO plans are not able to exchange medical out of pocket amounts with Beacon Health Options. When you've reached the annual out of pocket maximum under your HMO, you'll need to inform Beacon Health Options and provide proof by submitting the explanation of benefits received from your Medical HMO.

what the plan pays – mental health benefits

This section provides information about the network and out-of-network benefits for covered services. In certain situations, to receive the full benefits, you have to follow certain notification procedures. Keep in mind that the plan only pays benefits for covered charges for services, supplies, and treatment that are medically necessary and appropriate, as determined by Beacon Health Options, the claims administrator.

Inpatient Treatment and Alternative Levels of Care

Inpatient treatment includes all 24-hour, medically intensive levels of care, including acute inpatient and detoxification.

Alternative levels of care includes all alternatives to acute inpatient and detoxification, including residential treatment, day treatment, partial hospitalization, structured outpatient programs, and intensive outpatient programs.

Network	<ul style="list-style-type: none">• 100% of network provider charges with notification to Beacon Health Options within three business days of admission.• 60% of network provider charges without notification to Beacon Health Options, or the rate Beacon Health Options has negotiated for not providing notification, if lower.
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Out-of-Network Not covered.

Notification to Beacon Health Options

In order to receive the full benefits provided by the MHSA Plan, notification to Beacon Health Options is required. Notification to Beacon Health Options allows Beacon Health Options to review your provider's proposed treatment plan for medical necessity and advise your provider how many visits or days of care may be covered. When you visit a **network provider**, your provider can notify Beacon Health Options and submit a proposed treatment plan on your behalf. You or your provider should periodically check in with Beacon Health Options to ensure that your treatment plan continues to be covered. If the treatment plan is not covered, Beacon Health Options will advise your provider.

Inpatient services must meet medical necessity as determined by Beacon Health Options. Some services require pre-certification (for example, psychological testing and electroconvulsive therapy).

The plan provides coverage for inpatient treatment incurred while confined to a hospital or while being treated under an alternative level of care. Alternative level of care includes an intensive outpatient program or structured outpatient program which operates two to four days per week for at least three hours each day or partial hospitalization program which operates 3-5 days per week for 4-6 hours each day. This includes charges for prescription drugs if provided specifically as part of hospital inpatient or residential treatment center care.

The plan also provides coverage for day treatment which is generally less acute care where the patient is in a day or evening program.

No plan benefits are paid for custodial care.

Outpatient Office Visits

Outpatient office visits include individual, group, family, medication management.

Network **100%** of network provider charges.

Out-of-Network Not covered.

Outpatient services must meet medical necessity as determined by Beacon Health Options. Some services require pre-certification (for example, psychological testing and electroconvulsive therapy).

The plan provides coverage for outpatient office visits for the treatment of mental health problems. Included is treatment for serious conditions, such as depression, stress/anxiety, substance abuse, eating disorders, as well as everyday challenges such as family stress, relationship difficulties and problems at work.

The Mental Health and Substance Abuse Plan doesn't cover prescription drugs for outpatient office visit treatment. If you're prescribed a drug as part of your outpatient treatment, you should check with your medical HMO to find out if it can help pay for the drugs you need; otherwise, you'll be responsible for paying the full cost of prescribed outpatient medication.

Both Beacon Health Options and Chevron's EAP-WorkLife can help you locate a Beacon Health Options network provider in your area.

Emergency Services

Network **100%** of network provider charges.

Out-of-Network **100%** of billed charges.

If you or a dependent needs emergency care, you should go to the nearest hospital emergency room.

To qualify for plan benefits, emergency care must be required for the immediate diagnosis and treatment of a medical or mental condition that, if not treated immediately, could reasonably be expected to result in severe pain, permanent disability, serious medical complications, loss of life or danger to the patient or others.

Psychological Testing and Electroconvulsive Therapy

- | | |
|----------------|---|
| Network | <ul style="list-style-type: none">• 100% of network provider charges with notification to Beacon Health Options within three business days of admission.• 60% of network provider charges without notification to Beacon Health Options, <i>or</i> the rate Beacon Health Options has negotiated for not providing notification, if lower. |
|----------------|---|

Out-of-Network	Not covered
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Notification to Beacon Health Options

Advance notification to Beacon Health Options is required and services must be medically necessary and appropriate in order to receive the full benefits under the MHSA Plan. When you visit a **network provider**, your provider can notify Beacon Health Options and submit a proposed treatment plan on your behalf. You or your provider should periodically check in with Beacon Health Options to ensure that your treatment plan continues to be covered. If the treatment plan is not covered, Beacon Health Options will advise your provider.

what the plan pays – mental health benefits

This section provides information about the network and out-of-network benefits for covered services. In certain situations, to receive the full benefits, you have to follow certain notification procedures. Keep in mind that the plan only pays benefits for covered charges for services, supplies, and treatment that are medically necessary and appropriate, as determined by Beacon Health Options, the claims administrator.

Inpatient Treatment and Alternative Levels of Care

Inpatient Treatment – includes all 24-hour, medically intensive levels of care, including acute inpatient and detoxification.

Alternative Levels of Care - alternatives to acute inpatient and detoxification, including residential treatment, day treatment, partial hospitalization, structured outpatient programs, and intensive outpatient programs.

- | | |
|----------------|--|
| Network | <ul style="list-style-type: none">• 100% of network provider charges with notification to Beacon Health Options within three business days of admission.• 60% of network provider charges without notification to Beacon Health Options, or the rate Beacon Health Options has negotiated for not providing notification, if lower. |
|----------------|--|
-

Out-of-Network Not covered.

Notification to Beacon Health Options

In order to receive the full benefits provided by the MHSA Plan, notification to Beacon Health Options is required. Notification to Beacon Health Options allows Beacon Health Options to review your provider's proposed treatment plan for medical necessity and advise your provider how many visits or days of care may be covered. When you visit a **network provider**, your provider can notify Beacon Health Options and submit a proposed treatment plan on your behalf. You or your provider should periodically check in with Beacon Health Options to ensure that your treatment plan continues to be covered. If the treatment plan is not covered, Beacon Health Options will advise your provider.

Inpatient services must meet medical necessity as determined by Beacon Health Options. Some services require pre-certification (for example, psychological testing and electroconvulsive therapy).

The plan provides coverage for inpatient treatment incurred while confined to a hospital or while being treated under an alternative level of care. Alternative level of care includes an intensive outpatient program or structured outpatient program which operates two to four days per week for at least three hours each day or partial hospitalization program which operates 3-5 days per week for 4-6 hours each day. This includes charges for prescription drugs if provided specifically as part of hospital inpatient or residential treatment center care.

The plan also provides coverage for day treatment which is generally less acute care where the patient is in a day or evening program.

No plan benefits are paid for custodial care.

Office Visits

Office visits includes individual, group, family, medication management.

Network **100%** of network provider charges.

Out-of-Network Not covered.

Outpatient services must meet medical necessity as determined by Beacon Health Options. Some services require pre-certification (for example, psychological testing and electroconvulsive therapy).

The plan provides coverage for outpatient office visits for the treatment of substance abuse problems.

The Mental Health and Substance Abuse Plan doesn't cover prescription drugs for outpatient office visit treatment. If you're prescribed a drug as part of your outpatient treatment, you should check with your medical HMO to find out if it can help pay for the drugs you need; otherwise, you'll be responsible for paying the full cost of prescribed outpatient medication.

Both Beacon Health Options and Chevron's EAP-WorkLife can help you locate a Beacon Health Options network provider in your area.

Emergency Services

Network **100%** of network provider charges.

Out-of-Network **100%** of billed charges.

If you or a dependent needs emergency care, you should go to the nearest hospital emergency.

To qualify for plan benefits, emergency care must be required for the immediate diagnosis and treatment of a medical or mental condition that, if not treated immediately, could reasonably be expected to result in severe pain, permanent disability, serious medical complications, loss of life or danger to the patient or others.

expenses that aren't covered

This section provides important information about expenses that aren't covered by the Mental Health and Substance Abuse Plan.

In certain situations, Mental Health and Substance Abuse Plan benefits, or your eligibility for them, may be limited. For example, the plan doesn't pay for the following:

- Treatment, supplies or services not prescribed by a clinician (although not all treatment or services prescribed by a clinician are considered covered charges).
- Services that aren't considered medically necessary and appropriate, as determined by Beacon Health Options.
- Charges that you're not required to pay.
- Charges in excess of allowed charges.
- Charges resulting from failure to provide notification to the Plan.
- Charges for which a claim for benefits isn't filed within 365 days from the date on which a service was provided.
- Treatment provided by an immediate relative or someone who normally lives with you.
- Treatment, supplies or services furnished by a government facility or doctor, or payable under a government plan or program, except as required by law.
- Treatment of an injury that results from the patient's active participation in any of the following:
 - An insurrection or riot.
 - A crime, unlawful act or attempted crime.
 - War or any act of war (declared or undeclared) or international armed conflict or conflict involving armed forces of any international authority.
- Treatment of an injury or other loss that results from service in the armed forces of any government or international authority.
- Treatment for a condition covered by workers' compensation or other occupational disease law or sustained while working for compensation, profit or gain.
- Charges of a personal nature, such as the cost of newspapers, telephone, guest meals or rental of radios, television or bedside service tables, posture chairs and exercise equipment.
- Transportation costs.
- Charges that are reimbursed by an award or settlement that you receive from a third party for expenses for treating an injury or condition resulting from an act, or failure to act, of the third party.
- Experimental procedures, drugs or devices, as determined by Beacon Health Options in its sole discretion.
- Charges for services rendered while the patient isn't covered by the plan.
- Custodial care.
- Educational rehabilitation or treatment of learning disabilities (including pervasive development disorder and autism spectrum disorder).
- Charges for broken appointments or completing or filing claim forms.
- Charges for treatment of physical illness, including, but not limited to, cirrhosis and neurological disorders.

- Charges for services, supplies or treatment that are covered charges under the Chevron Medical PPO Plan, Chevron High Deductible Plan, Chevron High Deductible Health Plan Basic or another health care plan to which Chevron contributes, such as an HMO, including prescription drugs prescribed as part of outpatient treatment.
- Services furnished in response to a court order that aren't medically necessary and appropriate.
- Treatment of chronic pain, except for psychotherapy, biofeedback or hypnotherapy given in connection with a diagnosed psychiatric disorder.
- Aversion therapy.
- Treatment for personal growth or development.
- Treatment received to fulfill a requirement for professional certification.
- Charges for hypnotherapy, except when performed in connection with a diagnosed psychiatric disorder.
- Psychological testing, unless used to diagnose a psychiatric disorder or when given in conjunction with a diagnosed psychiatric disorder.
- Psychiatric or psychological examination, testing or treatments for obtaining or maintaining employment or insurance or relating to judicial or administrative proceedings.
- Private-duty nursing.
- Prescription drugs that are not prescribed as part of inpatient treatment under the MHSA Plan.
- Charges incurred prior to meeting the annual combined deductible.

claims and appeals

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

how to file a claim

If you go to a Beacon Health Options network provider for care, you generally don't have to file a claim form for network benefits. However, before your benefits can be paid, you must sign an authorization to release medical information. Beacon Health Options will send you an authorization form, or your provider may give you the form. Your provider will make arrangements with you if you need to pay for part of your treatment.

You may be billed directly by a provider if you live in an area where there aren't any providers in the Beacon Health Options network. If so, to be reimbursed for treatment, you'll have to file a claim form with Beacon Health Options.

You have to file a claim form if you use an out-of-network provider for services. You can get a claim form by calling Beacon Health Options. Claim forms are also available on the Benefits Connection website at **hr2.chevron.com** or from the HR Service Center. To ensure timely payment, you should file your claim as soon as you can. If you don't file a claim within 365 days from the date on which you incur a covered charge, no plan benefits will be payable for that covered charge.

initial claim review and decision

Beacon Health Options, the claims administrator, reviews claims and makes a decision to either approve or deny a claim (in whole or in part). You'll receive written notice of the status of your claim within 30 days after Beacon Health Options receives it. If there are special circumstances that require more time, Beacon Health Options will advise you that more time is needed and will send its decision within 45 days of receiving the claim. If additional information is needed, you will be notified during the initial 30-day period and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving your additional information or after the expiration of your 45-day deadline to complete the claim, whichever is earlier. Note, different time limits apply for urgent care and pre-service claims as described in the *Time Limits for Processing Claims* chart below.

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

Types of Claims

You will receive a written notice of the claim decision within the time limits described in the *Time Limits for Processing Claims* chart below. Those time limits are based on the type of claim and whether you submit a proper claim, including all necessary information.

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

- **Urgent care claim:** Any claim for medical care or treatment with respect to which the application of the time periods for making nonurgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or which, in the opinion of your doctor, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- **Preservice claim:** Any claim for a benefit with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on your obtaining approval before you receive such medical services.
- **PostsERVICE claim:** Any claim that is not a preservice claim — that is, does not require approval — and that is filed for payment of benefits after medical care has been received.

Another type of claim is the concurrent care claim. For more information, see Concurrent Care Claims in this section.

Time Limits for Processing Claims

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

- **Plan notice of improper or incomplete claim:** If you filed the claim improperly, or if additional information is needed to process the claim, you will receive a notice describing how to properly file the claim or describing the additional information needed.
- **Your deadline to complete the claim:** If you receive a notice from the plan that your claim is incomplete, you then have a deadline to complete the claim.
- **Plan notice of initial claim decision:** Once the plan receives a proper claim, the plan has a deadline to notify you of its decision.

Time Limits for Processing Claims

This chart describes the time limits for processing different types of claims.

Time Limits	Types of Claims		
	Urgent Care Health Claims	Preservice Health Claims	Postservice Health Claims
Plan notice of failure to follow the proper claim procedures	Not later than 24 hours after receiving the improper claim.	Not later than 5 days after receiving the improper claim.	N/A
Your deadline to provide additional information required by the plan to decide your claim	48 hours after receiving notice that additional information is required.	45 days after receiving notice that additional information is required.	45 days after receiving notice that additional information is required.
Plan notice of initial claim decision	<ol style="list-style-type: none"> Not later than 72 hours after receiving the initial claim, if it was proper and complete. Not later than 48 hours after receiving additional information or after the expiration of your 48-hour deadline to provide such information to complete the claim, whichever is earlier 	<ol style="list-style-type: none"> Not later than 15 days after receiving the initial claim, unless an extension, up to 15 days, is necessary due to matters beyond the control of the plan. The maximum time period is 30 days total. You will be notified within the initial 15 days if an extension is needed. Not later than 15 days after receiving the initial claim, unless you need to provide additional information. You will be notified during the initial 15-day period and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving your additional information or after the expiration of your 45-day deadline to complete the claim, whichever is earlier. 	<ol style="list-style-type: none"> Not later than 30 days after receiving the initial claim, unless an extension, up to 15 days, is necessary due to matters beyond the control of the plan. The maximum time period is 45 days total. You will be notified within the initial 30 days if an extension is needed. Not later than 30 days after receiving the initial claim, unless you need to provide additional information. You will be notified during the initial 30-day period, and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving your additional information or after the expiration of your 45-day deadline to complete the claim, whichever is earlier.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and your request to extend the treatment is an urgent care claim as defined under Types of Claims in this section, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The claims administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the time limits described above.

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

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

Notice and Payment of Claims

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

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

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

if your claim is denied

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

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

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

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

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

Time Limits for Processing Appeals

This chart describes the time limits for processing different types of appeals.

Time Limits	Types of Claims		
	Urgent Care Health Claims	Preservice Health Claims	Postservice Health Claims
Your deadline to file a first appeal	180 days after receiving the claim denial notice.	180 days after receiving the claim denial notice.	180 days after receiving the claim denial notice.
Plan notice of first appeal decision	Not later than 72 hours after receiving an appeal.	1. Not later than 15 days after receiving an appeal, if the plan allows two levels of appeal. 2. Not later than 30 days after receiving an appeal, if the plan allows one level of appeal.	1. Not later than 30 days after receiving an appeal, if the plan allows two levels of appeal. 2. Not later than 60 days after receiving an appeal, if the plan allows one level of appeal.
Your deadline to file a second appeal	N/A	90 days after receiving the first appeal denial notice.	90 days after receiving the first appeal denial notice.
Plan notice of second appeal decision	N/A	Not later than 15 days after receiving a second appeal.	Not later than 30 days after receiving a second appeal.
Your deadline to request an External Review	Four months after receiving the second appeal denial notice	Four months after receiving the second appeal denial notice	Four months after receiving the second appeal denial notice
IRO notice of External Review Decision	Not later than 72 hours after receiving the request for an External Review	Not later than 45 days after receiving the request for external review	Not later than 45 days after receiving the request for external review

how to file an appeal

First Appeal

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

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

Your appeal should include all of the following:

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

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

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

Where to Send Your Appeal

The MHSA Plan offers a second appeal, except that there is only one level of appeal for an urgent care claim. Send your appeal to the claims administrator:

Beacon Health Options
Review Authority
10805 Holder Street, Suite 300
Cypress, CA 90630

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

Time Limits and Procedures for Processing Your First Appeal

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

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

- The review on appeal will not afford deference to the initial denial, and it will be conducted by a fiduciary who is neither the individual who initially denied the claim that is the subject of the appeal nor the subordinate of such individual.
- If your claim is denied based in whole or in part on a medical judgment — including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate — the fiduciary reviewing the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.
- The health care professional consulted by the fiduciary reviewing the appeal will be an individual who is neither an individual who was consulted in connection with the denial of the claim that is the subject of the appeal nor the subordinate of such individual.
- Upon your request, the claims administrator will identify any medical or vocational experts whose advice was obtained on behalf of the plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.
- If the claims administrator considers, relies upon, or generates any additional or new evidence during the appeal or if the claims administrator will base an impending denial upon any new or additional rationale, the claims administrator will provide such evidence or rationale as soon as possible in advance of the date the decision is due to give you a reasonable opportunity to respond prior to the decision being issued.

Notice of Decision on First Appeal

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

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

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

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

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

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

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

Second Appeal

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

Time Limits and Procedures for Processing Your Second Appeal

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

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

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

Notice of Decision on Second Appeal

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

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

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

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

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

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

requesting an external review

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

- You were covered under the plan at the time the services were provided.
- The claim denial is not a result of failure to meet the requirements for eligibility under the plan.
- The claim denial involved medical judgment (for example, a denial based on the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit or a determination that a treatment is experimental or investigational) or the matter is a rescission of coverage.
- You have exhausted the appeal process described above.

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

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

Expedited External Review

You may request an expedited external review if any of the following apply:

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

To request an expedited external review, contact Beacon Health Options:

Beacon Health Options
Review Authority
10805 Holder Street, Suite 300
Cypress, CA 90630

Administrative Power and Responsibilities

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

how to file a claim for eligibility

If you have a question regarding your eligibility to participate in the Omnibus Health Care Plan or if you believe you are entitled to credit for health and welfare eligibility service, contact the HR Service Center to speak with a Customer Service Representative. If you are not satisfied with the outcome, you can file a claim by following the procedures described in this section.

how to file a claim for eligibility

If you have a question regarding your eligibility to participate in the Omnibus Health Care Plan or if you believe you are entitled to credit for health and welfare eligibility service, contact the HR Service Center to speak with a Customer Service Representative. If you are not satisfied with the outcome, you can file a claim by following the procedures described below. If you have been denied participation or if you believe you are entitled to credit for health and welfare eligibility service in the Omnibus Health Care Plan, you can file a written claim with the plan administrator. Include the grounds on which your claim is based and any documents, records, written comments or other information you feel will support the claim. Address your written correspondence to:

Chevron Corporation
Omnibus Health Care Plan Administrator
Chevron Human Resources Service Center
P.O. Box 18012
Norfolk, VA 23501

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

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

appeal procedures for denied claims

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

If your claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan is denied, in whole or in part, and you want to appeal the denial, you must file an appeal within 90 days after you receive written notice of the denial of your claim. The appeal must be in writing, must describe all of the grounds on which it is based, and should include any documents, records, written comments or other information you feel will support the appeal. Before submitting the appeal, you can review and receive, at no charge, copies of Omnibus Health Care Plan documents, records and other information relevant to your claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan. The Review Panel will provide you with a written response to the appeal and will either reverse the earlier decision and permit participation or provide credit for health and welfare eligibility service in the Omnibus Health Care Plan or it will deny the appeal. If the appeal is denied, the written response will contain:

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

The Review Panel doesn't have the authority to change Omnibus Health Care Plan provisions or Chevron policy or to grant exceptions to the Omnibus Health Care Plan rules or Chevron policy. For appeals regarding participation or credit for health and welfare eligibility service in the Omnibus Health Care Plan, address your written correspondence to:

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

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

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

if you're covered by more than one plan

Coordination of benefits is a feature used to determine how the Mental Health and Substance Abuse Plan will pay when you or one of your dependents is also covered under another group plan that provides coverage for treatment of mental health and substance abuse problems. This feature is designed to prevent overpayment of benefits.

If you're enrolled in one of the HMOs offered to Chevron employees and your HMO also provides coverage for treatment of mental health and substance abuse problems, you can choose to use your Mental Health and Substance Abuse Plan benefits through Beacon Health Options or the benefits provided under your HMO, but you cannot be reimbursed by your HMO and Beacon Health Options for the same services. The Mental Health and Substance Abuse Plan doesn't coordinate coverage with HMOs.

how it works

Under the coordination of benefits rules, one plan pays benefits first (the *primary payer*) and one plan pays second (the *secondary payer*). The primary payer pays the benefits provided by its plan features. The secondary payer then pays any excess amounts required to bring the total benefits paid up to the levels payable under its plan. If the Chevron Mental Health and Substance Abuse Plan is the secondary payer, the combined benefit from both plans won't total more than the Mental Health and Substance Abuse Plan's limit for the covered charges.

Different coordination of benefits rules apply under different circumstances.

Note: Coordination of benefits does not apply to benefits payable under any private accident or health insurance plans. Also, it does not apply to benefits payable under any other group insurance or medical care plan maintained by Chevron.

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

A plan other than the Mental Health and Substance Abuse Plan will be the primary payer if it meets any of the following conditions:

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

If the Chevron Mental Health and Substance Abuse Plan is the secondary payer, the combined benefit from both plans won't be more than the Mental Health and Substance Abuse Plan's limit for the covered charges.

Note: Coordination of benefits does not apply to benefits payable under any private accident or health insurance plans. Also, it does not apply to benefits payable under any other group insurance or health care plan maintained by Chevron.

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

If you're covered by the Mental Health and Substance Abuse Plan and your spouse/domestic partner is covered by another group plan that provides coverage for treatment of mental health and substance abuse problems (and the other group plan has a coordination of benefits rule), special rules apply to dependent children covered under both plans:

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

Note: Coordination of benefits does not apply to benefits payable under any private accident or health insurance plans. Also, it does not apply to benefits payable under any other group insurance or health care plan maintained by Chevron.

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

When parents are separated or divorced, or living apart due to termination of a domestic partnership, and there is no court order to the contrary, the following rules apply:

- The plan of the parent with custody of (or court-ordered financial responsibility for) the child is the primary payer.
- The plan of the spouse of the parent or domestic partner of the parent with custody of the child is the secondary payer (if the first bullet does not apply).
- The plan of the parent or domestic partner without custody (or court-ordered financial responsibility) pays last (if the first and second bullets do not apply).

Note: Coordination of benefits does not apply to benefits payable under any private accident or health insurance plans. Also, it does not apply to benefits payable under any other group insurance or health care plan maintained by Chevron.

other plan information

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

administrative information

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

Employer Identification Number (EIN)

The employer identification number is 94-0890210.

Plan Sponsor and Plan Administrator

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

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

1-888-825-5247

Chevron Corporation Mental Health and Substance Abuse Plan

This plan is part of the Omnibus Health Care Plan.

Plan number: 560

Claims Administrator:

Beacon Health Options | P.O. Box 1290 | Latham, NY 12110

www.valueoptions.com

Type of Administration: Contract administration

Type of Plan: Mental Health and Substance Abuse Benefits

Chevron Corporation Omnibus Health Care Plan

Plan number: 560

Type of Administration: Contract Administration

Type of Plan: Health plan

Agent for Service of Legal Process

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

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

You can also serve process by serving the plan administrator. If you have a dispute with a health maintenance organization (HMO), regarding benefits or claims, then any legal action should be directed to the agent for service of legal process appointed by the HMO as applicable. For information about the procedure for a QMCSO, please contact the HR Service Center.

Administrative Power and Responsibilities

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

Plan Amendments and Changes

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

Participating Companies

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

Collective Bargaining Agreements

If a union represents you, you're eligible for the 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 benefits 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 claim administrator in writing. If it's found that you or a beneficiary wasn't paid benefits you or your beneficiary was entitled to, the plan will pay the unpaid benefits.

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

Recovery of Overpayments

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

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

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

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

Plan Year

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

No Right to Employment

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

Future of the Plans

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

If a self-funded plan can't pay all of the incurred claims and plan expenses as of the date the plan is changed or terminated, Chevron Corporation will make sufficient contributions to the self-funded plan to make up the difference.

If all claims and expenses are paid and Chevron Corporation's book reserve established for the purpose of making contributions toward the cost of employees' health care coverage retains a balance, Chevron Corporation will determine what to do with the excess amount in view of the purposes of the plans. HMOs and DHMOs are fully insured health care offerings. Chevron is not responsible for the financial health of the HMO or DHMO or for the delivery of health services in the HMO or DHMO.

your ERISA rights

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

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

Receive Information About Your Plan and Benefits

You have the right to:

- Examine (without charge) at the plan administrator's office and at other specified locations, such as work sites, all Plan documents. These may include insurance contracts, collective bargaining agreements, official Plan texts, trust agreements and copies of all documents, such as the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain (by writing to the plan administrator) copies of all documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, copies of the latest Form 5500 annual report, and an updated SPD. The plan administrator can make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You have a right to continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. For information regarding your continuation coverage rights, review the Continuation Coverage and COBRA Coverage section and the documents governing the plan.

If You Have a Pre-existing Condition

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

- You lose coverage under the plan.
- You become entitled to elect continuation coverage.
- Your continuation coverage ceases.

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

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

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

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

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

- If you request a copy of the plan documents or the plan's latest annual report and do not receive them within 30 days, you can file suit in a federal court. In such a case, the court can require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials — unless the materials were not sent because of reasons beyond the control of the plan administrator.
- If you disagree with the plan's decision or lack of response to your request concerning the qualified status of a domestic relations order or medical child support order, you can file suit in a federal court.
- If you have a claim for benefits that is denied or ignored, in whole or in part, you can file suit in a state or federal court (see the Filing a Lawsuit section below).
- If it should happen that plan fiduciaries misuse the plan's money, or if you're discriminated against for asserting your ERISA rights, you can seek assistance from the U.S. Department of Labor or you can file suit in a federal court.

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

Assistance With Your Questions

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

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

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

Filing a Lawsuit

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

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

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

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

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

other legislation that can affect your benefits

Mental Health Parity and Addition Equity Act (MHPAEA) of 2008

The MHPAEA generally requires that financial requirements and treatment limitations placed on mental health and substance use disorder benefits must be no more restrictive than those placed on medical/surgical benefits.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

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

Chevron Corporation
Human Resources Service Center
P.O. Box 18012
Norfolk, VA 235018

third party responsibility

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

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

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

First Right of Recovery

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

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

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

Granting of an Equitable Lien by Contract

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

Creation of Constructive Trust

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

Your Responsibilities

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

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

Your Notice Obligations

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

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

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

No Duty to Independently Sue or Intervene

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

Recovery of Overpayments

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

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

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

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

continuation coverage and COBRA coverage

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

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

introduction

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

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

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

What Is Continuation Coverage?

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

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

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

Conversion Coverage

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

who's eligible for continuation coverage

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

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

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

qualifying events

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

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

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

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

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

Special Rule for Bankruptcy of the Employer

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

how to enroll

Chevron Must Give Notice of Some Events

Chevron has the responsibility to notify the HR Service Center, which handles Chevron's continuation coverage administration, when any of the following occurs:

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

You Must Give Notice of Some Events

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

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

The following information should be included in the notice:

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

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

You should provide your notice to the Chevron HR Service Center. Your personal identification number (PIN) will be required when reporting the event by telephone. Additionally, you can mail your notice to the following address:

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

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

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

Electing Continuation Coverage

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

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

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

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

Keep the Plan Informed of Address Changes

In order to protect your family's rights, you should keep Chevron informed of any changes in the addresses of family members by contacting the HR Service Center. You should also keep a copy, for your records, of any notices you send to the HR Service Center.

how much continuation coverage costs

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

how to pay for continuation coverage

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

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

Regular monthly COBRA payments by mail should be payable to the **Chevron HRSC** and must be mailed to:

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

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

Direct Debit Payment Option with the HR Service Center

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

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

when continuation coverage starts

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

How Long Continuation Coverage Lasts

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

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

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

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

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

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

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

Disability extension of 18-month period of continuation coverage

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

- Your continuation coverage qualifying event was an employee's termination of employment (for any reason other than gross misconduct) or a reduction in hours so that the employee (and you) was no longer eligible for Chevron health care benefits.
- The disability started at some time before the 60th day of continuation coverage and lasts at least until the end of the 18-month period of continuation coverage.
- A copy of the Notice of Award from the Social Security Administration is provided to the HR Service Center within 60 days of receipt of the notice and before the end of the initial 18 months of continuation coverage.
- If the disabled qualified beneficiary elects continuation coverage, you must pay an increased premium of 150 percent of the monthly cost of health plan coverage that's continued, beginning with the 19th month of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

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

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

Extension Due to Medicare Eligibility

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

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

when continuation coverage ends

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

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

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

important considerations when you leave chevron

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

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

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

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

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

Request an Intent to Retire Package

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

What if I Die?

Please see the **If You Die: Important Considerations** chapter for more information about access to survivor health benefits for your eligible dependents in the event you die while participating in Chevron retiree health benefits.

additional rights and rules

Special Rule:

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

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

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

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

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

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

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

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

How Much USERRA Continuation Coverage Costs

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

if you die: important considerations

This section provides an overview of what happens to medical benefits for your eligible dependents if you die.

what happens to health coverage

In all cases, your survivor(s) must take action to report your death to the HR Service Center within 31 days of your death to remain eligible for coverage. If a surviving spouse, surviving domestic partner or surviving dependent child misses the enrollment deadline, they become permanently ineligible for future Chevron health benefits and/or the Retiree HRA Plan. Eligibility will not be reinstated.

If enrolled in Chevron *employee* group health coverage

Your eligible surviving spouse, surviving domestic partner or surviving dependent child must be enrolled in Chevron employee benefits on the date of your death to qualify for survivor coverage or COBRA continuation coverage. If you are an eligible employee enrolled in Chevron employee benefits at the time of your death, your *enrolled* dependents are eligible for any one of the following:

- **COBRA continuation coverage.**
Your survivors are only eligible to elect COBRA coverage for the plans in which they are enrolled at the time of your death. See the **COBRA and Continuation Coverage** chapter of this summary plan description for more information about this coverage.
- **Chevron survivor health coverage.**
 - **Pre-65 eligible survivors** can participate in the Chevron group health coverage offered to pre-65 eligible retirees. See the **Chevron Pre-65 Retiree Health Benefits** summary plan description on hr2.chevron.com/retiree for a description of pre-65 health benefits.
 - **Post-65 eligible survivors** can participate in the individual medical, prescription drug, dental and vision coverage offered to Chevron retirees through OneExchange. Post-65 eligible surviving dependents are also eligible to participate in the Retiree HRA Plan. See the **Chevron Post-65 Retiree Health Benefits** summary plan description on hr2.chevron.com/retiree for a description of post-65 health benefits and the Chevron Retiree HRA Plan.

Your survivor(s) must take action to report your death to the HR Service Center within 31 days of your death to remain eligible for coverage. If a surviving spouse, surviving domestic partner or surviving dependent child misses the enrollment deadline, they become permanently ineligible for future Chevron health benefits and/or the Retiree HRA Plan. Eligibility will not be reinstated.

If a surviving spouse, surviving domestic partner or surviving dependent child **waives all health plan coverage**, they become permanently ineligible for future Chevron health plan coverage and the Retiree HRA Plan (if applicable). Coverage or eligibility will not be reinstated.

If enrolled in Chevron COBRA or Chevron subsidized COBRA coverage

Your survivor(s) must take action to report your death to the HR Service Center within 31 days of your death to remain eligible for coverage. If you — the Chevron eligible retiree — die while covered under Chevron COBRA or subsidized COBRA coverage:

- **Chevron COBRA continuation coverage.**

If your eligible surviving spouse, surviving domestic partner or surviving dependent child are also enrolled in Chevron COBRA coverage on the date of your death, your surviving dependents can continue their current COBRA coverage for the plans for which they are enrolled as your dependents on the date of your death. *Your surviving dependents are not eligible for Chevron survivor health coverage and/or the Retiree HRA. This means Chevron health coverage for surviving dependents ends permanently when their COBRA coverage period ends.*

- **Chevron subsidized COBRA continuation coverage.**

If your eligible surviving spouse, surviving domestic partner or surviving dependent child are also enrolled in Chevron *subsidized* COBRA coverage on the date of your death, your surviving dependents can continue their current subsidized COBRA coverage until the end of the subsidized period for the plans for which they are enrolled as your dependents on the date of your death. *However, if your surviving dependent chooses to remain on COBRA coverage beyond the subsidized period, they will become permanently ineligible for future Chevron survivor health benefits and/or the Retiree HRA Plan. Eligibility will not be reinstated.*

- **Chevron survivor health coverage.**

- **Pre-65 eligible survivors** can participate in the Chevron group health coverage offered to pre-65 eligible retirees. To remain eligible for survivor coverage, pre-65 eligible survivors must contact the HR Service Center within 31 days of the date of your death (or within 31 days of the date when subsidized COBRA coverage ends, if applicable). See the **Chevron Pre-65 Retiree Health Benefits** summary plan description on hr2.chevron.com/retiree for a description of pre-65 health benefits. If a surviving spouse, surviving domestic partner or surviving dependent child misses the enrollment deadline, they become permanently ineligible for future Chevron health benefits and/or the Retiree HRA Plan. Eligibility will not be reinstated.

- **Post-65 eligible survivors** can participate in the individual medical, prescription drug, dental and vision coverage offered to Chevron retirees through OneExchange. Post-65 eligible surviving dependents are also eligible to participate in the Retiree HRA Plan. See the **Chevron Post-65 Retiree Health Benefits** summary plan description on hr2.chevron.com/retiree for a description of post-65 health benefits and the Chevron Retiree HRA Plan.

- Medicare Part A and Part B is required to enroll in health coverage through OneExchange and to activate the Retiree HRA Plan.

- To remain eligible for survivor coverage, post-65 eligible survivors must contact **OneExchange** within 31 days of the date of your death. They must also call the **HR Service Center** within 31 days of the date of your death to activate the Retiree HRA Plan.

- If your post-65 eligible survivors are currently enrolled in Chevron **subsidized COBRA coverage** and wish to remain enrolled until the end of the subsidized period, they must contact OneExchange **three months** in advance of the subsidized COBRA end date to understand and begin the post-65 individual health coverage enrollment process. Failure to timely enroll through OneExchange could result in a gap in coverage. They must also call the HR Service Center within **31 days** of the date subsidized COBRA ends to activate the Retiree HRA Plan.

If a surviving spouse, surviving domestic partner or surviving dependent child misses an enrollment deadline, they become permanently ineligible for future Chevron health benefits and/or the Retiree HRA Plan. Eligibility will not be reinstated.

If a surviving spouse, surviving domestic partner or surviving dependent child **waives all health plan coverage**, they become permanently ineligible for future Chevron health plan coverage and the Retiree HRA Plan (if applicable). Coverage or eligibility will not be reinstated.

If not enrolled in health coverage

Your dependents are **not** eligible for Chevron COBRA or continuation or survivor coverage if any of the following apply:

- If, on the date of your death, you were not enrolled in Chevron employee coverage, Chevron retiree coverage, Chevron COBRA coverage, Chevron subsidized COBRA coverage, or another employer's group health coverage.
- If, on the date of your death, **your eligible dependents** were not enrolled as a dependent under your health coverage.

If enrolled in Chevron retiree health benefits

If you are a Chevron eligible retiree and die while covered under Chevron retiree health benefits, your eligible surviving spouse, surviving domestic partner or surviving dependent child must be enrolled in Chevron retiree health benefits on the date of your death to qualify for survivor coverage or COBRA continuation coverage. If you are an eligible retiree enrolled in the health benefits offered to Chevron eligible retirees on the date of your death, your *enrolled* dependents are eligible for either one of the following:

- **COBRA continuation coverage.**
Your survivors are only eligible to elect COBRA coverage for the plans in which they are enrolled on the date of your death.
 - See the **COBRA and Continuation Coverage** chapter of the **Chevron Pre-65 Retiree Health Benefits** summary plan description on hr2.chevron.com/retiree for more information about COBRA coverage for pre-65 retiree health coverage.
 - See the **COBRA and Continuation Coverage** chapter of the **Chevron Post-65 Retiree Health Benefits** summary plan description on hr2.chevron.com/retiree for more information about COBRA coverage for the Retiree HRA Plan.
 - COBRA and Continuation Coverage does not apply to the post-65 individual health plans offered through OneExchange.

- **Chevron survivor health coverage.**
 - **Pre-65 eligible survivors** can participate in the Chevron group health coverage offered to pre-65 eligible retirees. See the **Chevron Pre-65 Retiree Health Benefits** summary plan description on hr2.chevron.com/retiree for a description of pre-65 health benefits.
 - **Post-65 eligible survivors** can participate in the individual medical, prescription drug, dental and vision coverage offered to Chevron retirees through OneExchange. Post-65 eligible surviving dependents are also eligible to participate in the Retiree HRA Plan. See the **Chevron Post-65 Retiree Health Benefits** summary plan description on hr2.chevron.com/retiree for a description of post-65 health benefits and the Chevron Retiree HRA Plan.

Your survivor(s) must take action to report your death to the HR Service Center within 31 days of your death to remain eligible for coverage. If a surviving spouse, surviving domestic partner or surviving dependent child misses the enrollment deadline, they become permanently ineligible for future Chevron health benefits and/or the Retiree HRA Plan. Eligibility will not be reinstated.

If a surviving spouse, surviving domestic partner or surviving dependent child **waives all health plan coverage**, they become permanently ineligible for future Chevron health plan coverage and the Retiree HRA Plan (if applicable). Coverage or eligibility will not be reinstated.

If enrolled in another employer's group health coverage

If you are a Chevron eligible retiree and die while covered under another employer's group health plan, eligible dependents that are also covered under your group health plan on the date of your death can enroll in Chevron survivor health coverage.

- **Pre-65 eligible survivors** can participate in the Chevron group health coverage offered to pre-65 eligible retirees. See the **Chevron Pre-65 Retiree Health Benefits** summary plan description on hr2.chevron.com/retiree for a description of pre-65 health benefits.
- **Post-65 eligible survivors** can participate in the individual medical, prescription drug, dental and vision coverage offered to Chevron retirees through OneExchange. Post-65 eligible surviving dependents are also eligible to participate in the Retiree HRA Plan. See the **Chevron Post-65 Retiree Health Benefits** summary plan description on hr2.chevron.com/retiree for a description of post-65 health benefits and the Chevron Retiree HRA Plan.

An **employer group health plan** is defined as an employee health benefit plan established or maintained by an employer or by an employee organization (such as a union), or both, that provides medical care for participants or their dependents directly or through insurance, reimbursement, or otherwise. Retiree health insurance from a former employer or union or COBRA are not considered coverage based on current employment.

Your survivor(s) must take action to report your death to the HR Service Center within 31 days of your death to remain eligible for coverage. If a surviving spouse, surviving domestic partner or surviving dependent child misses the enrollment deadline, they become permanently ineligible for future Chevron health benefits and/or the Retiree HRA Plan. Eligibility will not be reinstated.

If a surviving spouse, surviving domestic partner or surviving dependent child **waives all health plan coverage**, they become permanently ineligible for future Chevron health plan coverage and the Retiree HRA Plan (if applicable). Coverage or eligibility will not be reinstated.

making changes to survivor health benefits

Once enrolled, survivors can make benefit changes during:

- Chevron's open enrollment period for COBRA participants.
- Chevron's open enrollment period for pre-65 participants.
- Medicare's Annual Enrollment Period (AEP) for post-65 Medicare-eligible participants.

Survivors can also make changes during the year, when there is a qualifying life event (the change must be consistent with the qualifying life event as defined by Chevron or Medicare, as applicable).

- **For COBRA and pre-65 participants**, Contact the HR Service Center within 31 days of the date of the qualifying life event to make benefit changes.
- **For post-65 participants**, contact OneExchange within 31 days of the date of the qualifying life event to make benefit changes.

In all cases, there are some exceptions to the types of changes survivors are permitted to make, as follows:

- **Survivors cannot add additional dependents.** If a survivor adds an additional dependent to coverage, health coverage and/or participation in the Retiree HRA Plan will be canceled. (Up to 36 months of COBRA continuation coverage becomes available for health coverage only.)
Exception: An eligible retiree/employee's dependent child who is born within nine months of the date of the eligible retiree/employee's death can be added to health coverage as long as the surviving spouse or domestic partner is enrolled in Chevron pre-65 group health coverage and the newborn is added to coverage as a dependent within 31 days of the date of birth.
- **If a survivor drops all health care coverage**, the survivor and any existing, enrolled dependents they become permanently ineligible for future Chevron health plan coverage and the Retiree HRA Plan (if applicable). Coverage or eligibility will not be reinstated.
- **If a survivor drops an existing, enrolled dependent**, the dependent becomes permanently ineligible for future Chevron health plan coverage and the Retiree HRA Plan (if applicable). Coverage or eligibility will not be reinstated.

cost of survivor health benefits

COBRA Continuation Coverage

If your enrolled dependent(s) elects **COBRA continuation coverage**, they must pay the entire cost of each applicable plan plus a 2 percent administrative fee.

Survivor Coverage

Chevron may pay a portion of the cost of survivor coverage. Contact the HR Service Center or OneExchange for information as it pertains to your situation.

how long survivor health benefits last

Survivor coverage for a surviving spouse or domestic partner can continue until:

- The survivor dies.
- The survivor cancels coverage.
- The survivor does not make timely premium payments.
- Survivor coverage can continue if the survivor remarries or enters into a new domestic partner relationship, but the new spouse or domestic partner or any other new dependents cannot be added to any Chevron health benefit. If the survivor wants to add the new spouse or other new dependent to the plan, survivor coverage and/or the Retiree HRA will be canceled. (Up to 36 months of COBRA continuation coverage becomes available for health coverage only.) The only exception to this rule is a retiree/employee's dependent child who is born within nine months of the date of the retiree/employee's death can be added as long as the newborn is added to coverage as a dependent within 31 days of the date of birth.

Survivor coverage for enrolled children can continue until:

- The child reaches age 26 (unless incapacitated).
- Is no longer eligible according to the eligibility provisions for the health plans for reasons other than your – the retiree – death. Please see the **Eligibility** chapter for details on eligibility.
- Survivor coverage can continue if the child marries or enters into a new domestic partner relationship, but the new spouse or domestic partner or any other new dependents cannot be added to any Chevron health plan. If the child wants to add the new spouse or other new dependent to their Chevron health plan, survivor coverage ends, and up to 36 months of continuation coverage becomes available.

Survivor coverage will end early:

- If the survivor fails to timely pay any required premiums for coverage.
- As of the date the survivor has received the maximum benefit under a particular Chevron health plan.

Survivor coverage will also end if Chevron ceases to provide any health plan for any of its employees or retirees. Survivor coverage may also be terminated if you commit fraud or make an intentional misrepresentation of a material fact.

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

glossary

Allowed Charges

Allowed charges are the basis for reimbursements that the plan will pay for medically necessary services and supplies that are prescribed by an out-of-network clinician, hospital or other provider and that are covered by the plan. Allowed charges for services and supplies may vary from one geographic area to another and are based on the prevailing level of charges for the same service in a specific geographical area. Allowed charges must be no more than the out-of-network clinician normally charges for the service or supply. When reviewing charges to determine if they're covered under the plan's out-of-network coverage, Beacon Health Options doesn't attempt to set the amount that nonparticipating clinicians charge for services, nor does Beacon Health Options restrict your right to go to any clinician you choose. However, Beacon Health Options does determine the allowed charges, and you're responsible for paying the difference between your out-of-network clinician's charge and the allowed charge as established by Beacon Health Options.

For an employee who is an Expatriate in the U.S. and his enrolled dependents, the term **allowed charges** includes billed charges for an out-of-network provider. For services provided outside the U.S., **allowed charges** means **billed charges**.

Alternative Level of Care

A structured mental health and/or substance abuse treatment program that:

- Is supervised by an M.D., D.O. or other practitioner who qualifies as a Clinician, and
- Is a facility-based, acute inpatient alternative, and
- Lasts from a few hours a few days per week, to 24 hours per day, to 7 days per week (for residential treatment, the patient may spend the night), and
- Includes a variety of treatment methods, which may include medical services, group and/or individual psychological, vocational and recreational therapies, and
- Is licensed, certified or approved by the state in which the program operates.

alternative level of care includes acute inpatient treatment alternatives including day treatment, Residential Treatment Program, Structured Outpatient Program, Intensive Outpatient Program, and Partial Hospitalization Program.

Beacon Health Options

The Mental Health and Substance Abuse Plan's claims administrator, Beacon Health Options has a broad network of professional health care providers in many locations throughout the U.S. Beacon Health Options reviews the treatment processes that these providers use and approves (or denies) proposed treatment plans. In addition, Beacon Health Options provides administrative services, such as paying providers and processing claims for benefits. Contact information is available from the **Benefit Contact Information** chapter of this summary plan description.

Beacon Health Options Network

The Beacon Health Options network includes over 7,000 facilities and 49,000 behavioral health clinicians across the U.S. to assist you. The network does not include providers or facilities outside of the U.S. Counselors from Beacon Health Options and Chevron's Employee Assistance and WorkLife Services provide referrals to network providers in your area when you or a dependent needs treatment for a mental health or substance abuse problem. Contact information is available from the **Benefit Contact Information** chapter of this summary plan description.

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.

Chevron's Employee Assistance

A division of Chevron's medical staff that employs or contracts for the services of a staff of counselors who provide crisis counseling, assessment and referrals for employees and dependents seeking treatment for mental health and substance abuse problems and, solely for eligible employees, may provide case management and notification services for substance abuse problems. Contact information is available from the **Benefit Contact Information** chapter of this summary plan description.

Claims Administrator (Beacon Health Options)

Beacon Health Options is the Mental Health and Substance Abuse Plan's claims administrator in all states. See the **Benefit Contact Information** chapter at the front of this summary plan description for contact information for Beacon Health Options.

Clinician

A physician (M.D/D.O.), psychiatrist (M.D.), psychologist, social worker, counselor or nurse who is licensed or certified for independent practice by the proper authority of the state in which he or she practices and who is practicing within the scope of his or her license or certificate. In states where state law does not provide for licensure or certification, "social worker" means a professional certified by the National Board of Examiners in Clinical Social Work or the American Board of Examiners in Clinical Social Work.

Coinsurance Rate

The percentage of any Covered Charges that the MHSA Plan pays.

Common-Law Employee

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

Company

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

Copayment

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

Corporation

Refers to Chevron Corporation.

Custodial Care

Care consisting of accommodations (including room and board and other institutional services) and services provided because of an individual's age or other mental or physical condition (rather than care for the treatment of illness or injury). Custodial care includes assisting the individual in the activities of daily living, such as eating, walking, taking medicine, bathing and changing bed positions, which could be provided safely and reasonably by persons without professional skills or training.

Custodial care also includes health-related services that don't seek to improve the patient's medical condition, or that are provided when the patient's medical condition is not changing.

Domestic Partner

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

Domestic Partner's Dependent Child

See the **Eligibility** chapter of this summary plan description for the definition of an eligible domestic partner's dependent child.

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 Dependent Child

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

Eligible Employee

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

Eligible Provider

The term eligible provider refers to a Hospital, alternative level of care or Clinician.

Eligible Spouse

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

Emergency Services

Services required to provide an immediate diagnosis and treatment of a medical or mental condition of sudden and unpredictable onset. Such condition must be marked by acute symptoms of sufficient severity which, in the absence of emergency medical attention, could reasonably be expected to result in severe pain, permanent disability, serious medical complications, loss of life or danger to self or others.

Experimental, Investigational, or Unproven Service

A medical, surgical, diagnostic, psychiatric, substance abuse or health care service, technology, supply, treatment, procedure drug therapy or device that is any of the following:

- Not approved by the U.S. Food and Drug Administration to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial as defined by FDA regulations, regardless of whether the trial is subject to FDA oversight.
- Not demonstrated to be safe and effective for treatment or diagnosing the condition or illness for which its use is proposed, based on peer-reviewed medical literature.

Health and Welfare Eligibility Service (HWES)

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

Chevron High Deductible Health Plan (HDHP)

Chevron High Deductible Health Plan (or HDHP) means the Chevron High Deductible Health Plan, Supplement Plan Q to the Omnibus Health Care Plan of Chevron Corporation, as it may be amended from time to time.

Chevron High Deductible Health Plan Basic (HDHP Basic)

Chevron High Deductible Health Plan Basic (or HDHP Basic) means the Chevron High Deductible Health Plan Basic, Supplement Plan R to the Omnibus Health Care Plan of Chevron Corporation, as it may be amended from time to time.

HIPAA

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

Hospital

A hospital must meet one of the following requirements:

- A legally constituted and operated institution having, on the premises, organized facilities (including organized diagnostic and treatment facilities) for the care and treatment of members with a covered mental health and/or substance abuse illness under the supervision of a staff of legally qualified physicians, with a Registered Nurse (R.N.) on duty at all times; *or*
- A free-standing rehabilitative facility that meets all of the following criteria:
 - Has a provider agreement, as required by Medicare.
 - Serves an inpatient population of whom a majority require intensive treatment or rehabilitative services for the treatment of mental health and/or substance abuse.
 - Has a preadmission screening procedure to determine whether the patient would benefit from an intensive inpatient hospital program.
 - Ensures that patients receive appropriate medical supervision and furnishes rehabilitation nursing, detoxification, psychotherapy, substance abuse counseling, etc., by hiring qualified personnel.
 - Establishes a plan of treatment for every patient that is reviewed as needed by a physician who consults with other qualified personnel.
 - Uses a coordinated team approach to rehabilitate each patient.

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

- Any institution or part of that is used primarily as a rest or nursing facility.
- Any facility for the aged, chronically ill, or convalescents
- Any facility providing primarily educational or custodial care.

Incapacitated Child

An incapacitated child is a dependent child who is:

- Incapable of self-sustaining employment by reason of mental retardation or a mental or physical disability (proof of which must be medically certified by a physician).
- Dependent on you, you and your spouse/domestic partner or your surviving spouse/domestic partner who is covered under the plan, for more than one-half of his or her financial support.
- Your or your spouse/domestic partner's qualifying child under section 152 of the Internal Revenue Code. This means that during the calendar year the individual 1) is your child, brother, sister stepbrother, stepsister or a descendent of such person; 2) lives with you for more than one-half the year and 3) does not provide over one-half of his or her own support.

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

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

When the child reaches age 26 and periodically thereafter, Chevron Corporation will require you to provide documentation stating that the child continues to be incapacitated. For chronic disabilities, as determined by Chevron's medical plan administrator, you must provide documentation every two years. If the disability is not chronic, Chevron's medical plan administrator will determine how frequently you will need to provide such documentation. For details, contact the HR Service Center.

Inpatient Treatment

Hospital, Residential Treatment Program, Alternative Level of Care, Intensive Outpatient Program, Structured Outpatient Program or similar treatment provided in a behavioral health facility.

Intensive Outpatient Program

A structured level of care in continuum between day treatment and traditional outpatient treatment which operates two to four days per week for a least three hours each day.

Leased Employee

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

Medically Necessary

Mental health and substance abuse service, supplies and treatments which are all of the following:

- Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (ICD-10 or DSM-V) that threatens life, causes pain or suffering or results in illness or infirmity.
- Expected to improve an individual's condition or level of functioning.
- Individualized, specific and consistent with symptoms and diagnosis and not in excess of patient's needs.
- Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications.
- Reflective of a level of service that is safe, where no equally effective, more conservative and less costly treatment is available.
- Not primarily intended for the convenience of the recipient, caretaker or provider.
- No more intensive or restrictive than necessary to balance safety, effectiveness and efficiency.
- Not a substitute for non-treatment services addressing environmental factors.

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

Mental Health Services

Services provided by a Hospital, Clinician, or other licensed provider for the diagnosis or treatment of mental illness.

Network Provider

An Eligible Provider who is designated by Beacon Health Options as being part of its network of providers.

Network Provider Charges

The rate to be charged for Network Services provided by a Hospital, Clinician or other treatment facility when Beacon Health Options has negotiated a specific rate with the Network Provider.

Nurse

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

Open Enrollment

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

Out-of-Pocket Maximum

After you pay your deductible, the plan pays a percentage of covered charges for the care you need and you pay any costs above the amount paid by the plan. After your out-of-pocket costs reach the specified amount for the coverage tier, the plan pays 100 percent of all covered charges until the end of the calendar year. With respect to a participant in HDHP or HDHP Basic there is one combined out-of-pocket maximum for medical, prescription drugs, mental, health and substance abuse services.

Partial Hospitalization Program (PHP)

A structured therapeutic program either attached to a Hospital or free standing which operates 3-5 days per week for 4-6 hours each day. A PHP must be under supervision/oversight of a Medical Director/Licensed Program Director and must provide physician-supplied medication management services. Staff must include physicians, nurses, psychologists and social workers and, if for substance abuse, substance abuse education and treatment. A PHP must have written admission and discharge criteria, individualized treatment plan and a full treatment program schedule, including individual therapy. A PHP must have a documented patient/psychiatrist visit at least one time per week.

Payroll

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

Primary Payer

The plan that pays benefits first.

Professional Intern

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

Regular Work Schedule

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

Residential Treatment Program or Residential Treatment Center

A program of treatment given in a facility that meets all of the following:

- Provides 24-hour residential care to patients who don't require acute care services or 24-hour nursing care.
- Provides structured mental health and/or substance abuse treatment that includes medical supervision by a doctor (M.D./D.O.) and is staffed by a multidisciplinary team, which may include doctors (M.D.s, Ph.D.s), psychologists, social workers, substance abuse counselors, registered nurses (R.N.s) and other health care professionals.
- Is licensed, certified or approved by the state in which the program operates.

Seasonal Employee

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

Secondary Payer

The plan that pays benefits second.