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Medical and Dental HMO

Summary Plan Description (SPD)
Effective January 1, 2014

This document provides information about the Medical and Dental HMO Plans for you and your eligible dependents. If you choose a medical or dental health maintenance organization (HMO or DHMO) as your Chevron medical or dental coverage, you should review this document for information on plan eligibility and participation. For information about all other aspects of your coverage, you should review the evidence of coverage (EOC) (sometimes called a *certificate of coverage*) provided by your HMO or DHMO. If you choose HMO coverage, the insurer for the plan is the HMO or DHMO you elect.

This information constitutes the summary plan description (SPD) of the Medical and Dental HMO Plans 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 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.

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 medical and dental benefits that apply to you.

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

Table of Contents

Key Benefit Contacts

Human Resources (HR) Service Center

If you have questions regarding your plan options, eligibility and enrollment, please call the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).

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

U.S. Benefits HR2 Website on the Internet

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

- **hr2.chevron.com**

U.S. HR Website on the Chevron Intranet

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

- **hr.chevron.com/northamerica/us/**

ADP Benefit Services

COBRA and Continuation Coverage

- 1-888-825-5247 (Inside the U.S.) Select option 2, then " * "
- 610-669-8595 (Outside the U.S.) Select option 2, then " * "

Medical and Dental HMO Plans

If you choose medical or dental HMO coverage, the insurer administrator for the plan is the HMO you elect. For questions about your coverage, you should contact the plan directly.

- You can reach your HMO or DHMO at the website addresses and telephone numbers shown on your member ID card.
- Or get your plan's information by calling the HR Service Center (see above).
- Or get your plan's information on the U.S. Benefits HR2 Website on the Internet (see above).

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Update to the Summary Plan Description
Effective January 1, 2016

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

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

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

This SMM applies to the following summary plan description:

- **January 1, 2014 Medical and Dental HMO Summary Plan Description** (both the individual SPD posted online and the Your Chevron Health Benefits Summary Plan Description for U.S.-Payroll Employees compilation available in print.)

Tobacco Surcharge Changes

New *Tobacco User Trying to Quit* requirements for 2016.

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

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

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

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

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

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

How to Update Your Tobacco Use Status

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

Certification Choices for 2016

Your 2016 tobacco certification choices and requirements are as follows:

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

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

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

What's Considered Tobacco Use

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

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

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

Medical HMO Plans

Chevron offers several health maintenance organization (HMO) medical plan options that include medical coverage, prescription drug coverage and basic vision coverage. With an HMO you must visit a provider in the HMO's network, otherwise your benefits aren't covered (except for certain emergency situations). HMOs are not available in all areas and the plan choices vary based on your zip code. The Benefits Connection enrollment website will indicate if an HMO is available in your area and the website will display the monthly cost for each plan available to you. Typically, you need a referral to a specialist under the Medical HMO Plans.

The Medical HMO Plans offer comprehensive coverage for the major medical services you'd expect, including office visits, emergency services, hospital care, lab services, outpatient care, pregnancy and newborn care and rehabilitative services.

- **Medical Services, Prescription Drugs, Basic Vision:** Provided by the HMO

Preventive Care

All Medical HMO Plans include 100 percent coverage with no deductible for certain preventive care services as specified by the Affordable Care Act when you see a network provider. Additional preventive screenings and services may also be covered, depending on factors like your age and gender.

Deductibles

There are generally no deductibles in the Medical HMO Plans, but coinsurance or copayments generally apply for all covered services and supplies.

Health Care Spending Account (HCSA)

You *are eligible* to participate in the Health Care Spending Account (HCSA), a flexible spending account. The funds you contribute to this account do not roll over from year to year. Learn more about the HCSA on **hr2.chevron.com**. Choose **Open Enrollment**.

Health Savings Account (HSA)

You *cannot* participate in a health savings account when enrolled in a Medical HMO Plan. However, you can use funds from an *existing* HSA to pay for qualified medical expenses while participating in a Medical HMO Plan.

Mental Health and Substance Abuse (MHSA) Plan

If you are enrolled in a Chevron Medical HMO Plan, you have the choice to use the mental health and substance abuse benefits provided by your HMO Plan, or to use the benefits provided under the MHSA Plan administered by ValueOptions, a Beacon Health Company. However, you cannot make a claim to **both** your HMO Plan and ValueOptions for the same service. If you are enrolled in a Chevron Medical HMO Plan and you choose to use your ValueOptions MHSA benefit, remember you **must** use a ValueOptions network provider to receive benefits. Out-of-network provider services are covered for emergencies only.

	Medical HMO Plans
Monthly Premium This is the fixed amount of money you pay each month to be covered by your health plan. Chevron also currently contributes money each month to help pay for your premium.	**Varies.** The monthly premium is based on the plans available in your area (if any). Go to the Benefits Connection website to see your HMO options and the monthly cost. (See Page 8.)
Annual Deductible This is the amount you pay out of pocket before your health plan begins to help pay for covered health care services.	**No Deductibles.** You generally don't need to satisfy a deductible before your plan shares costs with you — you'll just have to pay a copayment and/or coinsurance for covered services and prescription drugs. Remember, to receive coverage, you *must* use an HMO network provider, except in certain emergency situations. *Note: Certain union HMO plans have a deductible requirement. See your plan's Summary of Benefits and Coverage (SBC) on* **hr2.chevron.com** *for details.*
Out-of-Pocket Maximum This amount is the most you will have to pay out of pocket for covered health care services for the year. When you reach this amount, your health plan begins to pay 100 percent of the allowed amount for covered health care services. This amount is important because it protects you in the event you have a year with major health expenses.	**Varies.** The out-of-pocket maximum is based on the plans available in your area (if any). Go to the Summary of Benefits and Coverage (SBC) posted on **hr2.chevron.com** to review the limits for each of your available HMO plans.

Tobacco Surcharge

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

For More Information

Be sure to go to **hr2.chevron.com** for access to a variety of other resources.

Medical HMO - Altius UT Will Not Be Offered in 2016

This plan will no longer be available to active employees effective January 1, 2016. If you are currently enrolled in this plan, you will be automatically enrolled in the **Medical PPO Plan – Option 1** effective January 1, 2016. No action is required, but if you want to enroll in another Chevron medical option available to you, you must make an election during open enrollment, October 19 through October 30, 2015.

Other Medical HMO Plan Changes

If you participate in a Medical HMO offered by Chevron, note that your provider or other plan features, like monthly premiums, copayments or prescription drug coverage could still change. **We've provided the highlights of major changes in the table below, but there could be additional details or other changes received after the printing of this newsletter. Always refer to the 2016 Evidence of Coverage document available for each plan to learn about your HMO plan changes.** Contact the HMO directly to request a copy. You can find HMO contact information on **hr2.chevron.com** or by calling the HR Service Center.

2016 Medical HMO Plan Change Highlights

Medical HMO - Health Plan HI

- Durable Medical Equipment coverage will increase from 50% to **80% covered**.
- Hawaii mandate for **autism coverage** now included.

Medical HMO - Group Health WA

- Outpatient Rehabilitation visit limit will be reduced from 60 visits per year to **45 visits per year**.
- Inpatient Rehabilitation visit limit will be reduced from 60 days per year to **30 days per year**.

Medical HMO - Kaiser HI

- Specialty Drug tier added (**$75** retail, **$150** mail-order).
- Skilled Nursing Facility care day limit will be increased from 100 days to **120 days**.

Medical HMO - Altius UT

- This plan **will no longer be available** to active employees effective January 1, 2016.

Medical HMO Plan Reminders

An HMO option may be available to you in your area. The Benefits Connection website will list the HMOs available to you next year (if any).

- **Your provider or other plan features, like monthly premiums, copayments or prescription drug coverage could change.** See your plan's Summary of Benefits and Coverage (SBC) for more information about your plan's features or contact the HMO directly (See Page 10).
- **Even if your current HMO will be available in 2016, that doesn't guarantee that it is still available to you.** Each year, the HMOs review the ZIP codes and counties in which they have providers. An HMO may choose to discontinue coverage to residents of certain areas.
- **Your HMO provider may have changed.** Remember that HMOs require you to use doctors, dentists and hospitals that are part of their provider network. Contact your medical or dental HMO directly to find out if your current providers continue to be in the network. If they are not, you will need to change providers or choose a new plan to ensure that your medical and dental services continue to be covered.
- **Copayment and other changes in your current HMO coverage may apply** because of state filings, compliance with the Health Care Reform law provisions, or to make them more closely align with Chevron's standard benefit design. You'll be able to view more information about HMO plan changes, if any, in the 2016 Evidence of Coverage document available for each HMO plan. Contact the HMO directly to request a copy.

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Update to the Summary Plan Description
Effective January 1, 2015

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

This SMM applies to the following summary plan description:

- **January 1, 2014 Medical and Dental HMO Plans Summary Plan Description** (both the individual SPD posted online and the Your Chevron Health Benefits Summary Plan Description for U.S.-Payroll Employees compilation available in print.)

How to Certify Your Tobacco Use Status

All employees (including employees on a leave of absence who are not receiving coverage through COBRA) are required to certify their tobacco use status during open enrollment, October 20 through October 31, 2014.

During this year's open enrollment period, October 20 through October 31, 2014, all U.S.-payroll employees who participate in Chevron medical or supplemental life insurance coverage will be required to certify their tobacco use status. **If you fail to follow the steps to certify your tobacco use status during open enrollment, you'll be charged the higher monthly rates for medical and supplemental life insurance coverage for all of 2015, whether or not you use tobacco.** You will not lose your coverage in these plans if you fail to certify, but you will pay the higher rate. If you miss the deadline, you cannot change your tobacco use status until next year's open enrollment for 2016 benefits.

Note: COBRA participants are not required to certify their tobacco use status at this time.

Tobacco use can affect your health. And your health is important to your quality of life, your family, your career, and the health of our business. That's why Chevron announced an important change to medical and supplemental life insurance coverage earlier this year. Starting January 1, 2015, Chevron will establish a tobacco surcharge for medical and supplemental life insurance coverage. This means there will be different monthly rates for this coverage for tobacco and non-tobacco users.

It matters to Chevron that you're in good health at work and at home. That's why we offer a variety of wellness programs and resources to encourage and support better health. We hope our employees — tobacco and non-tobacco users alike — take advantage of these opportunities, whether it's to try to stop using tobacco, participate in exercise programs, or take steps to protect your heart.

How to Certify

You can certify your tobacco use status by calling the HR Service Center (see Page 6) or by going online to Benefits Connection, the same website you use to make open enrollment elections. If you access Benefits Connection, from the Chevron network, you can use the automatic sign-in feature and you don't need a PIN. But if you need to certify your tobacco use status from outside the Chevron network or by phone, you'll need your PIN. A PIN reminder was mailed to you in September, but if you still don't know your PIN or can't find it, you can request a new one online or by calling the HR Service Center. It can take up to two weeks to receive your PIN in the mail, so take action right away if you need it.

- Go to **hr2.chevron.com** and click **Open Enrollment**, then the **Certify Tobacco Status** button.
- Login to Benefits Connection. Choose the **Enroll Today** button, then the **Make Your Elections Now** button.
- From the **Make Coverage Elections** screen, look for **Tobacco Certification** and choose **Change**.
- After you certify your tobacco use status, your **Make Coverage Elections** screen will be updated according to your certification choice.

Your Certification Choices

When you certify your tobacco use status, you'll be asked to choose from the status options listed below. Here's what those choices are and what they mean.

Tobacco User
Tobacco use is a personal choice. It's not our goal to intrude on your personal life and take away that choice. That's why if you currently use tobacco, you can continue using it. If you're a tobacco user and don't intend to stop using tobacco, you'll pay $25 more each month in 2015 for medical coverage than employees who are not tobacco users. If you participate in Chevron's Supplemental Life Insurance Plan, you'll also pay 20 percent more each month in 2015 for that coverage. The higher rates will take effect on January 1, 2015. Your benefit plan and the level of coverage you receive will be the same as non-tobacco users, the only difference will be that you pay a higher monthly cost for your coverage.

Tobacco User, But Will Try to Quit
If you commit to try to stop using tobacco during 2015, we have support resources to help you, and you'll pay the lower monthly rate too. Go to **hr2.chevron.com** for resources.

Not a Tobacco User
If you don't use tobacco you will not be subject to the higher medical and supplemental life insurance rates in 2015 as long as you certify your tobacco use status during open enrollment, October 20 through October 31. If you fail to meet this deadline, you'll be charged the higher monthly rates for medical and supplemental life insurance coverage for all of 2015.

Decline to Disclose
You can choose to decline to disclose your tobacco use status, but you'll be charged the higher monthly rates for medical and supplemental life insurance coverage for all of 2015, whether or not you use tobacco.

What's considered tobacco use?

You'll be asked to indicate your tobacco use status only. You don't have to certify the tobacco use status of your spouse or domestic partner and other dependents for 2015. Any use, regardless of frequency or location, is considered use. This includes daily, occasional or social use. It also includes if it's used only at your home. Use of the following since July 1, 2014, will be considered tobacco use:

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

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

Description of the Plan

Overview

Chevron offers medical HMO and dental DHMO plans in some areas. Typically, once you pay a copayment, most HMO and DHMO services are covered at 100 percent.

- Please keep in mind that if you choose an HMO or a DHMO, the only benefits you're eligible to receive are from network providers. Generally, you will not receive a benefit if you obtain services outside the plan's network, unless you need emergency care, as defined by the plan. HMO and DHMO networks can change during the year; however, you will not be allowed to change plans if your provider leaves the network. You must select another participating provider.

- If you choose a medical HMO, you are not eligible for medical, vision or prescription drug benefits provided by any of the other Chevron medical plans. However, you are eligible for benefits under the Mental Health and Substance Abuse Plan, as noted below. If you choose a dental HMO, you are not eligible for dental benefits provided by another Chevron dental plan.

- If you're an eligible employee, you're automatically covered by the Mental Health and Substance Abuse Plan offered by Chevron. If your eligible dependents are enrolled in a medical plan to which Chevron contributes, they're also automatically enrolled in the Chevron Mental Health and Substance Abuse Plan. Benefits from the Chevron Mental Health and Substance Abuse Plan are separate from any mental health or substance abuse benefits provided by your HMO.

- Keep in mind that not all HMOs are alike. Costs and covered services (including prescription drug, vision care, mental health and substance abuse coverage and preventive services) vary by HMO. For details, refer to your HMO Evidence of Coverage.

Note: There may be situations where state laws require the HMO to grant extended eligibility to its participants or their dependents. Please contact the HMO for further information.

Review the Evidence of Coverage for Plan Features

If you choose a medical or dental health maintenance organization (HMO or DHMO) as your Chevron medical or dental coverage, you should review this section for information on plan eligibility and participation. For information about all other aspects of your coverage, you should review the evidence of coverage (EOC) (sometimes called a *certificate of coverage*) provided by your HMO or DHMO. The EOC explains covered services, including prescription drugs, supplies and treatment for HMOs. It also describes the plan's exclusions and limitations and explains how to obtain care, file a claim (if necessary) and appeal a denied claim. You may be able to obtain this information from the website for your health care plan, or you can obtain a copy by contacting your plan directly. To locate a list of providers, you can access the website for your plan or call the plan's customer services unit.

Review the Summary Plan Descriptions for Mental Health and Substance Abuse and Vision Plus Information

This section only discusses the Medical and Dental HMOs. If you need information about the Mental Health and Substance Abuse Plan or the Vision Plus Program, see the corresponding summary plan descriptions.

Types of Health Maintenance Organizations (HMOs)

Medical Health Maintenance Organization (HMO)

Typically, HMOs are more cost-effective than preferred provider organization (PPO) plans. Under an HMO, once you pay a copayment, most services are covered at 100 percent. One of the biggest trade-offs for this type of coverage is less flexibility when selecting a provider; HMOs require that you use a provider within the HMO's network. Generally, you will not receive a benefit if you obtain services outside the HMO network unless you need emergency care, as defined by the HMO. There are other trade-offs as well. HMO doctor networks can change during the year. If your HMO provider leaves the network during the year, you will have to wait until the next open enrollment period or move outside of the HMOs service area to make a plan change. Most HMOs require you to select a primary care physician (PCP) who oversees your care and reviews your need to see a specialist. And, to keep costs lower, many HMOs have more stringent restrictions related to their prescription drug benefits.

Dental HMO

Dental HMOs (DHMOs) generally cover preventive and diagnostic services, basic and major services, and some orthodontia. They often use a copayment arrangement. As with medical HMOs, you must use a provider within the DHMO network. Typically, no benefits are paid for out-of-network services except emergency treatment as defined by the plan.

How to Contact Your Medical or Dental HMO

If you choose HMO coverage, the insurer for the plan is the HMO or DHMO you elect. For questions about your coverage, you should contact the plan directly. You can reach your HMO or DHMO at the website addresses and telephone numbers shown on your member ID card. You can also get your plan's contact information by calling the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). Or visit the Benefits Connection website at **hr2.chevron.com**.

Eligibility

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

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

Note for Expatriates: If you're a resident U.S.-payroll expatriate, HMO and DHMO plans generally are not available to you. Typically your only option for Chevron-sponsored dental coverage as a U.S.-payroll expatriate is the Dental PPO Plan. See the Dental PPO Plan summary plan description for details. In addition, non-U.S.-payroll expatriates working in the United States are not eligible for the HMO and DHMO plans. Non-U.S.-payroll expatriates working in the United States should refer to the *Health Benefits for Expatriates in the U.S.* summary plan description for information about the medical and dental benefits that apply to you.

Eligible Employees

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

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

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

- You're not on the Chevron U.S. payroll, or you're compensated for services to Chevron by an entity other than Chevron — even if, at any time and for any reason, you're deemed to be a Chevron employee.
- You're a leased employee or would be a leased employee if you had provided services to Chevron for a longer period of time.
- You enter into a written agreement with Chevron that provides that you won't be eligible.

- You're not regarded by Chevron as its common-law employee and for that reason it doesn't withhold employment taxes with respect to you — even if you are later determined to have been Chevron's common-law employee.

- You're a member of a collective bargaining unit (unless eligibility to participate has been negotiated with Chevron).

- You're eligible to receive benefits from the Chevron International Healthcare Assistance Plan (IHAP).

- You're a professional intern.

You may become eligible for different benefits at different times. Chevron Corporation, in its sole discretion, determines your status as an eligible employee and whether you're eligible for the plan. Subject to the plan's administrative review procedures, Chevron Corporation's determination is conclusive and binding.

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

Chevron Human Resources Service Center
P.O. Box 199708
Dallas, TX 75219-9708

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

Eligible Spouse

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

- Enrolled as an eligible employee.

- Enrolled as an eligible retiree.

- On active duty in the armed forces of any state, country or international authority.

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

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

Eligible Domestic Partner

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

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

1. You and your partner are all of the following:

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

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

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

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

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

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

You can enroll your registered domestic partner for health coverage — under the same plan(s) you're enrolled in. 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 and/or eligible retirees, each of you can enroll for individual coverage, or one of you can cover the other as a dependent. However, only one of you can enroll all of your children for coverage.

Eligible Children and Other Dependents

You can enroll a dependent child for coverage if he or she is all of the following:

- 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.

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

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

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

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

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

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

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

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

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

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

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

Participation

This section provides important information about participation in a Chevron-sponsored HMO or DHMO.

When and How You Can Enroll

If you are eligible, you must enroll to be covered by the Medical or Dental HMO plans offered by Chevron. The following chart contains important enrollment-related information.

A Snapshot of What to Do When

The following chart highlights when and how to enroll in Chevron's medical and dental plans.

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

Before-Tax vs. After-Tax Contributions

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

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

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

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

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

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

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

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

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

- You live in California and meet all of the requirements of the California Family Code section 297 definition of a domestic partner, including the requirement to have registered your domestic partner with the Secretary of State's office. For more information, visit the California Domestic Partnership website at **www.ss.ca.gov/business/sf/sf_dp.htm**. If you reside in California, you will be exempt from imputed income if you report that your domestic partner meets the state's requirement of a tax dependent and you report that you have registered your domestic partner or with the Secretary of State.
- You live in another state such as Oregon or the District of Columbia that recognizes domestic partnerships and you meet 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 at 1-888-825-5247 (610-669-8595 outside the U.S.) to speak with a Customer Service Representative.

Making Changes

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

Plan	Types of Changes
Company-Sponsored Medical HMO Plans	• You can change your medical plan elections only during open enrollment. Changes take effect the following January 1. Changes to your plan elections outside of the open enrollment can only be made if there's a qualifying life event. • You can switch to another medical plan if you're in an HMO and you move out of its service area. • If you pay for your coverage on an after-tax basis, you can cancel your coverage or drop dependents from coverage at any time.
Company Sponsored Dental HMO Plans	• During open enrollment, you can switch to another dental plan if one is available in your area. Changes take effect the following January 1. • You can switch to another dental plan if you're in the Concordia Plus dental HMO, the CIGNA Dental Care HMO or Hawaii Dental Services PPO and you move out of their service area. • You can't otherwise change your plan elections unless there's a qualifying life event. • If you pay for your coverage on an after-tax basis, you can cancel your coverage or drop dependents from coverage at any time.

Before-Tax Contribution Plan	• You can change the tax status of your health plan contributions (before-tax to after-tax or vice versa) during any open enrollment. Changes take effect the following January 1. You can't otherwise change your plan elections unless there's a qualifying life event.

Midyear Changes
If you pay for your health coverage on a before-tax basis, because of the plan's tax advantages, the Internal Revenue Service (IRS) restricts your ability to make changes to your benefits after initial enrollment. In general, once you enroll for (or decline) coverage, your benefit elections stay in effect for the entire plan year. However, under certain circumstances, you can enroll for or change certain coverages during the year (for example, if you experience a qualifying life event that affects your, your spouse's/domestic partner's, or your dependent's eligibility for plan benefits).

Qualifying Life Events
You can change certain benefit elections during the plan year if you experience a qualifying life event that results in a loss or gain of eligibility under the plan for yourself, your spouse/domestic partner or your dependent children. Changes can be made to your medical and dental coverage as long as the changes are consistent with, and correspond to, the qualifying life event.

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

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

- You commence or return from a leave of absence under the Family and Medical Leave Act of 1993 (FMLA).

- You qualify for a special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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

Special Enrollment Rights Under HIPAA

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

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

Special Enrollment Due to Loss of Other Coverage

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

- COBRA continuation coverage that has since ended.

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

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

- Legal separation.

- Divorce.

- Death.

- Ceasing to be a dependent as defined by the terms of a plan.

- Termination of employment.

- Reduction in the number of hours of employment.

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

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

- You or one of your dependents incurs a claim that would meet or exceed a lifetime limit on all benefits under the terms of a plan.

- A plan no longer offers any benefits to the class of similarly situated individuals to which you or any of your dependents belong.

- You or one of your dependents who has coverage through an HMO/DHMO no longer resides, lives or works in the HMO/DHMO service area.

You and your dependents must meet certain other requirements as well:

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

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

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

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

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

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

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

- **Effective date of coverage:** Coverage takes effect:

  - **Upon marriage:** On the first day of the month coinciding with or following the date of marriage.
  - **Upon formation of a domestic partnership:** On the first day of the month coinciding with or following the date all of the requirements of the *Chevron Affidavit of Domestic Partnership* are first met.
  - **Upon birth:** On the date of the dependent's birth.
  - **Upon adoption or placement for adoption:** On the date of such adoption or placement for adoption.
  - **When adding a child (other than your own newborn or adopted child) to your coverage:** On the first day of the month coinciding with or following the date the child first becomes your dependent.

Special Enrollment Due to the Children's Health Insurance Program (CHIP)
The Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 extends and expands the State Children's Health Insurance Program (SCHIP). The Act establishes special enrollment rights for employees and their dependents that are eligible for, but not enrolled in coverage under an employer-provided group health plan (such as the Chevron health plans). You and your dependents are eligible to enroll for Chevron health coverage as long as you apply within 60 days of the date either of the following occurs:

- Medicaid or CHIP coverage is terminated due to loss of eligibility.

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

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

- The first day of the month after the Medicaid or CHIP coverage ended, or

- The first day of the month following the date you first become eligible for the premium assistance subsidy.

More information, including a listing of states that currently have premium assistance programs, is available in the Other Legislation That Can Affect Your Benefits chapter, Free or Low-Cost Health Coverage to Children and Families section of this summary plan description.

When Participation Begins

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

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

When Participation Ends

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

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

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

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

A Snapshot of When Coverage Ends
The following chart shows additional rules regarding when coverage ends under each plan.

Plan	Participation Ends When:
Medical and Dental HMO Plans	• You or your dependent is no longer eligible. Coverage ends on the last day of the month. • You cancel coverage or stop making required contributions. Coverage for you and your dependents ends on the last day of the month for which contributions were received. • You move out of the service area of your current medical or dental plan and you must change to a plan offered where you live. New coverage takes effect on the first day of the following month. • Coverage for you and your dependents also ends after 31 days of the following types of leave: — Personal Leave Without Pay. — Leave for Educational Reasons. — Long Union Business Leave (unless you elect to pay 100% of the cost of continued coverage).
Before-Tax Contribution Plan	• As a result of a qualifying life event, you stop participating in all of the health plans to which Chevron requires you to contribute. • You elect to make contributions on an after-tax basis (participation ends on the following December 31). • You transfer to a company that doesn't participate in the plan. • You no longer receive a paycheck from Chevron and, as a result, you're unable to make before-tax contributions. • You're no longer eligible to participate because of a plan change, a change in your employment status or other reasons. • The plan is terminated or your employer stops participating in the plan.

What Happens if You Die
If you die, your enrolled dependents are eligible for either continuation coverage or retiree and survivor coverage. For more information, see the Continuation Coverage and COBRA Coverage chapter and the Retiree and Survivor Coverage section.

How Much You Pay for Coverage

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

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

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

HMO/DHMO Claim Disputes and Appeals

If you have a dispute with your HMO or DHMO about a claim for benefits or to appeal a denied claim, you should follow your HMO/DHMO's procedures to resolve your claim. Refer to your Evidence of Coverage for details. You may be able to obtain this information from the website for your health care plan, or you can obtain a copy by contacting your HMO or DHMO plan directly. If your dispute concerns eligibility to participate in the plan, you must follow the procedures described in the How to File a Claim for Eligibility section of this summary plan description.

How to File a Claim for Eligibility

This section describes how to dispute decisions regarding your eligibility to participate in Chevron's health plans or for credit for health and welfare eligibility service.

If you have a question regarding your eligibility to participate in the Omnibus Health Care Plan or if you believe you are entitled to credit for health and welfare eligibility service, contact the HR Service Center at 1-888-825-5247, option 2, (610-669-8595 outside the U.S.). If you are not satisfied with the outcome, you can file a claim by following the procedures described below.

If you have been denied participation or if you believe you are entitled to credit for health and welfare eligibility service in the Omnibus Health Care Plan, you can file a written claim with the plan administrator. Include the grounds on which your claim is based and any documents, records, written comments or other information you feel will support the claim. Address your written correspondence to:

Chevron Corporation
Omnibus Health Care Plan Administrator
Chevron Human Resources Service Center
P.O. Box 199708
Dallas, TX 75219-9708

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

If the claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan is denied (in whole or in part), the plan administrator will send you a written explanation that includes:

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

Appeal Procedures for Denied Claims

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

If your claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan is denied, in whole or in part, and you want to appeal the denial, you must file an appeal within 90 days after you receive written notice of the denial of your claim.

The appeal must be in writing, must describe all of the grounds on which it is based, and should include any documents, records, written comments or other information you feel will support the appeal. Before submitting the appeal, you can review and receive, at no charge, copies of Omnibus Health Care Plan documents, records and other information relevant to your claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan.

The Review Panel will provide you with a written response to the appeal and will either reverse the earlier decision and permit participation or provide credit for health and welfare eligibility service in the Omnibus Health Care Plan, or it will deny the appeal. If the appeal is denied, the written response will contain:

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

The Review Panel doesn't have the authority to change Omnibus Health Care Plan provisions or Chevron policy or to grant exceptions to the Omnibus Health Care Plan rules or Chevron policy.

For appeals regarding participation or credit for health and welfare eligibility service in the Omnibus Health Care Plan, address your written correspondence to:

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

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

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

How HMO Participation Affects Other Benefits

If you choose to participate in a Chevron-sponsored HMO, you are not eligible for health benefits provided through another Chevron-sponsored medical plan. This includes medical and prescription drug benefits. However, you are eligible for the Mental Health and Substance Abuse (MHSA) Plan and the Vision Plus Program, as described below. You may also be eligible for other plans or programs under the Omnibus Health Care Plan such as wellness programs or Health Decision Support.

Coordination of Benefits

If you participate in a Chevron-sponsored HMO and are also covered by another employer's plan (for instance, if you are covered by your spouse's medical plan), the HMO may have special rules for determining how benefits are paid. Contact your HMO or see the HMO's evidence of coverage for coordination-of-benefits rules.

If You're Eligible for Medicare:

- **Active employees:** If you're an active employee and you or an enrolled dependent is eligible for federal Medicare due to age or disability, your HMO is the generally the primary payer and Medicare is the secondary payer.

- **Disability Leave:** If you're on leave of absence and receiving Long-Term Disability benefits, the government no longer considers you an active employee. If you become eligible for Medicare due to disability, Medicare becomes the primary payer of benefits for you and any Medicare-eligible dependents. If your HMO does not offer coverage to Medicare participants, you will need to choose another Chevron-sponsored plan. If your HMO does cover Medicare participants, you will need to enroll in Medicare Part B and enroll in the Medicare version of the HMO.

Mental Health and Substance Abuse Plan

If you're an eligible employee, you're automatically covered under the Mental Health and Substance Abuse (MHSA) Plan administered by ValueOptions. Your dependents who are enrolled in a medical plan to which Chevron contributes are also covered. If you're enrolled in one of the HMOs offered to Chevron employees you may also have coverage with the HMO for treatment of mental health and/or substance abuse problems. Each time you access care, you can choose to use benefits under the MHSA Plan or benefits that may be provided under your HMO. However, you cannot claim the same charges under both plans. The MHSA Plan doesn't coordinate coverage with HMOs. Keep in mind that the MHSA Plan does not cover outpatient prescription drugs. You may want to check with your HMO to see if outpatient prescription drugs are covered for mental health or substance abuse treatment before deciding which plan — the MHSA Plan or your HMO plan — to use. To learn more about the MHSA Plan, see the Mental Health and Substance Abuse summary plan description.

Vision Plus Program

If you are an eligible employee then you are eligible to participate in the Vision Plus Program. Vision Plus is a voluntary option that provides prescription eyewear coverage. You can elect to purchase Vision Plus coverage even if you are not enrolled in the Chevron Medical PPO or a Chevron Medical HMO plan. You can also enroll your eligible dependents. Vision Plus is in addition to any vision coverage already provided by your HMO plan. If you enroll, your coverage automatically includes both Basic coverage (which includes eye exams) and Vision Plus coverage (which includes prescription eyewear). You can choose to use your HMO coverage for eye exams or your Vision Plus coverage — it's your choice. To learn more about the Vision Plus Program, see the Vision Plus Program summary plan description.

Wellness Programs

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

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 administrator and can be reached at the following address:

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

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

Chevron Health Maintenance Organization (HMO) Plans
This plan is part of the Omnibus Health Care Plan.

Plan number: 560

Claims Administrator:
The HMO you select at enrollment processes your claims. Claims should be sent to the address given on the claim form, if any.

Type of Administration: Insurer Administration

Type of Plan: Medical Benefit

Chevron Dental Health Maintenance Organization (DHMO) Plans
This plan is part of the Omnibus Health Care Plan.

Plan number: 560

Claims Administrator/Insurer:
The DHMO you select at enrollment processes your claims. Claims should be sent to the address given on the claim form, if any.

Type of Administration: Insurer Administration

Type of Plan: Dental Benefit

Chevron Corporation Omnibus Health Care Plan
Plan number: 560 **Type of Administration:** Contract Administration **Type of Plan:** Health Plan

Before-Tax Contribution Plan
Plan number: 721 **Type of Administration:** Company Administered **Type of Plan:** Health Contribution (Cafeteria Plan)

Agent for Service of Legal Process

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

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

If you have a dispute with a health maintenance organization (HMO), a dental health maintenance organization (DHMO), or VSP (for the vision program) regarding benefits or claims, then any legal action should be directed to the agent for service of legal process appointed by the HMO, DHMO, or VSP, as applicable. You can also serve process on a plan by serving the plan administrator.

For information about the procedure for a QMCSO, please contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).

Administrative Power and Responsibilities

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

Plan Amendments and Changes

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

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

Collective Bargaining Agreements
If a union represents you, you're eligible for the health care plans, provided both of the following apply:

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

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

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

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

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

Incorrect Computation of Benefits
If you believe that the amount of the benefit you receive from the plan is incorrect, you should notify the appropriate insurer in writing. If it's found that you or a beneficiary wasn't paid benefits you or your beneficiary was entitled to, the insurer will pay according to the terms of the insurance contract.

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 insurer 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. In addition, HMOs and DHMOs are subject to the insurance mandates and regulations of the state(s) in which they operate. The HMO or DHMO itself or the state in which the HMO or DHMO operates has the right to change or terminate the HMO or DHMO offering within any applicable state insurance regulations. Claims incurred after a plan is terminated won't be covered.

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 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, please call the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).

Your personal identification number (PIN) will be required when making this request. Additionally, you can mail your request to the following address:

Chevron Corporation
Human Resources Service Center
P.O. Box 199708
Dallas, TX 75219-9708

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

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

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

- If you request a copy of the plan documents or the plan's latest annual report and do not receive them within 30 days, you can file 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

Over the years, several federal laws have been passed that can affect your benefits under certain circumstances.

Newborns' and Mothers' Health Protection Act of 1996

In accordance with the Newborns' and Mothers' Health Protection Act of 1996, the plan may not restrict benefits for a mother's or newborn child's hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, the law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable) following delivery.

Reconstructive Surgery and Procedures

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

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

You may need to contact your HMO before any reconstructive surgery to make sure you qualify for full benefits.

Mental Health Parity Act of 1996

Under the Mental Health Parity Act of 1996, as amended from time to time, health plan dollar limits for mental health cannot be lower than for other plan services. Limits may be imposed on the number of visits and days covered.

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 in order 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, please call the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). Your personal identification number (PIN) will be required when making this request. Additionally, you can mail your request to the following address:

Chevron Corporation
Human Resources Service Center
P.O. Box 199708
Dallas, TX 75219-9708

Free or Low-Cost Health Coverage to Children and Families

Offered by Medicaid and the Children's Health Insurance Program (CHIP)

If you are eligible for health coverage (medical, dental, vision) from Chevron or another employer, but you're unable to afford the monthly premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance with paying their health premiums.

- **If you or your dependents are already enrolled in Medicaid or CHIP** and you live in a participating state, contact your state's Medicaid or CHIP office to find out if premium assistance is available.

- **If you or your dependents are not currently enrolled in Medicaid or CHIP**, but you think you or your dependent(s) might be eligible for either of these programs, contact your state's Medicaid or CHIP office. You can also call 1-877-KIDS NOW (1-877-543-7669) or visit **www.insurekidsnow.gov** to learn how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, then Chevron is required to allow you and your dependents to enroll in a company-offered plan. To qualify for this special enrollment opportunity, you must be eligible for Chevron coverage, but not already enrolled. **In addition, you must contact the Human Resources (HR) Service Center and request Chevron health coverage within 60 days of being determined eligible for Medicaid or CHIP premium assistance**. If you enroll timely, Medicaid or CHIP will subsidize, or pay for, a portion of the Chevron health plan premium cost.

If you have any questions

Please call the HR Service Center toll-free at 1-888-825-5247 (610-669-8595 outside the U.S.) to speak with a Customer Service Representative. Customer Service Representatives are available from 6 a.m. to 5 p.m., Pacific time (8 a.m. to 7 p.m., Central time), Monday through Friday, except on holidays.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2013. You should contact your State for further information on eligibility

ALABAMA – Medicaid	**COLORADO** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	**FLORIDA** – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218

LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647

RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

Third Party Responsibility

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

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

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

First Right of Recovery

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

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

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

Granting of an Equitable Lien by Contract

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

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

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

- Not to assign any rights or causes of action you may have against others (including under insurance policies) without the express written consent of the health plans.

- To take possession of any property subject to the health plans' equitable lien by contract in your own name, place it in a segregated account within your control (at least in the amount of the equitable lien by contract), and not to alienate it or otherwise take any action so that it is not in your possession prior to the satisfaction of such equitable lien by contract.

- That if such property is not in your possession (other than in possession by or on behalf of the health plans), to immediately take whatever steps possible to regain possession or have possession transferred to or on behalf of the health plans pursuant to their direction.

- To cooperate with the health plans and take any action that may be necessary to protect the health plans' right to recovery.

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

- The possibility that benefits paid by the health plans may be the responsibility of a third party.

- The submission of any claim or demand letter, the filing of any legal action, the request for any alternative dispute resolution process, or the commencement date of any trial or alternative dispute resolution process, regarding or related to any property that may be subject to the health plans' rights (1) of subrogation, reimbursement and restitution, (2) to an equitable lien by contract, and (3) as beneficiary of a constructive trust.

- Any agreement that any property that may be subject to the health plans' rights (1) of subrogation, reimbursement and restitution, (2) to an equitable lien by contract, and (3) as beneficiary of a constructive trust will be paid to or on behalf of you and/or your covered dependent (whether pursuant to resolution of a claim, legal action, alternative dispute resolution proceeding, or otherwise).

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

No Duty to Independently Sue or Intervene

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

Recovery of Overpayments

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

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

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

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

Continuation Coverage and COBRA Coverage

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

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

Introduction

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

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

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

What Is Continuation Coverage?

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

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

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

Conversion Coverage

If you are enrolled in an insured plan or HMO, and you ~~do~~ 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 dental coverage, mental health and substance abuse coverage, the Healthy Heart Program, Health Decision Support, or Executive Physical Program.

Who's Eligible for Continuation Coverage

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

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

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

Qualifying Events

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

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

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

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

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

Special Rule for Bankruptcy of the Employer

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

How to Enroll

Chevron Must Give Notice of Some Events

Chevron has the responsibility to notify ADP Benefit Services, which handles Chevron's continuation coverage administration, when any of the following occurs:

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

You Must Give Notice of Some Events

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

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

The following information should be included in the notice:

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

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

You should provide your notice to the Chevron HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S. Your personal identification number (PIN) will be required when reporting the event by telephone. Additionally, you can mail your notice to the following address:

Chevron Corporation
Human Resources Service Center
P.O. Box 199708
Dallas, TX 75219-9708

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

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

Electing Continuation Coverage

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

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

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

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

Keep the Plan Informed of Address Changes

In order to protect your family's rights, you should keep Chevron informed of any changes in the addresses of family members by contacting the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). You should also keep a copy, for your records, of any notices you send to the HR Service Center.

How Much Continuation Coverage Costs

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

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

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

Regular monthly COBRA payments should be mailed to:

ADP Benefit Services – COBRA
P.O. Box 7247-0367
Philadelphia, PA 19170-0367

Or via overnight to:

ADP Benefit Services – COBRA Lockbox 0367
c/o Citibank Lockbox Operations
1615 Brett Road
New Castle, DE 19720-2425

When Continuation Coverage Starts

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

How Long Continuation Coverage Lasts

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

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

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

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

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

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

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

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

- Your continuation coverage qualifying event was an employee's termination of employment (for any reason other than gross misconduct) or a reduction in hours so that the employee (and you) was no longer eligible for Chevron health care benefits.

- The disability started at some time before the 60th day of continuation coverage and lasts at least until the end of the 18-month period of continuation coverage.

- A copy of the Notice of Award from the Social Security Administration is provided to the HR Service Center within 60 days of receipt of the notice and before the end of the initial 18 months of continuation coverage.

- If the disabled qualified beneficiary elects continuation coverage, you must pay an increased premium of 150 percent of the monthly cost of health plan coverage that's continued, beginning with the 19th month of continuation coverage.

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

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

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

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

When Continuation Coverage Ends

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

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

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

Continuation Coverage vs. Retiree and Survivor Coverage

If you qualify as an eligible retiree at the time of your termination of employment with Chevron, you will have the option to elect either one of the following for you and your covered dependents:

- Retiree and survivor coverage.
- Continuation coverage.

The costs for retiree and survivor coverage and continuation coverage may differ. You should carefully review the information provided to you by Chevron at the time you terminate employment with Chevron.

Although you have the option to elect either retiree and survivor coverage, or continuation coverage, generally, if you don't enroll in retiree and survivor coverage when you first become eligible, then you can only elect retiree and survivor coverage during an open enrollment period. However, there are a few exceptions as follows:

- This provision does not apply if you were a former employee who was eligible for both subsidized COBRA and retiree medical coverage and initially elected subsidized COBRA coverage. In this case you can immediately enroll in retiree medical coverage after your subsidized COBRA coverage ends, provided you do so within 31 days of the subsidized COBRA coverage ending.
- This provision does not apply if you and your dependents are covered by another Group Plan upon your death. In this case, your survivors are able to elect coverage under the retiree and survivor plan, provided they do so within 31 days of your death.

Elections you make during an open enrollment period will become effective at the beginning of the next calendar year, unless you have a qualifying life event (for example, you get married or divorced) that is subject to midyear special enrollment rights.

Continuation Coverage Considerations

If you don't elect continuation coverage …
If you qualify as an eligible retiree and *don't* elect continuation coverage, you and your eligible dependents that were enrolled in a Chevron health plan on the day before the qualifying event will be automatically enrolled in retiree and survivor coverage with Chevron. Retiree and survivor coverage will be effective retroactively to the first day of the month following your termination of employment. You may still elect continuation coverage during the 60-day election period. If you elect continuation coverage after you have been automatically enrolled in retiree and survivor coverage, your retiree and survivor coverage will be retroactively canceled.

If you elect continuation coverage …
If you qualify as an eligible retiree at the time of your termination of employment with Chevron and you elect continuation coverage, you may enroll in retiree and survivor coverage at a later time, but only during an open enrollment period. However, there are a few exceptions that apply – please see above.

Special exceptions if you are eligible for subsidized COBRA …
If you are eligible for both retiree medical coverage and subsidized COBRA, and you initially elect subsidized COBRA coverage, some of the provisions above do not apply to you:

- You can immediately enroll in retiree and survivor coverage after your subsidized COBRA coverage has ended, as long as you do so within 31 days of the subsidized coverage ending. You do not have to wait for an open enrollment period.

- If you die while enrolled in subsidized COBRA, your survivors can immediately enroll in retiree and survivor coverage after subsidized COBRA coverage has ended, as long as they do so within 31 days of the subsidized coverage ending.

- If you die while enrolled in another employer's group health plan, your survivors can immediately enroll in retiree and survivor coverage after your death, as long as they do so within 31 days of your death.

Retiree and Survivor Coverage Considerations

If you die, your enrolled dependents are eligible for either continuation coverage (described under Continuation Coverage and COBRA Coverage in this section) or survivor coverage under Chevron's health plans. Chevron currently pays a portion of the cost for survivor coverage. However, if your enrolled dependent(s) elect continuation coverage, they must pay the entire cost plus a 2 percent administrative fee.

Your enrolled dependents may elect survivor coverage within 31 days of your death. Upon timely receipt of any required premiums, an election of survivor coverage will be effective retroactive to the day after the day that the survivor's (and his or her covered dependent(s), if applicable) coverage under Chevron's health plans terminates. In the event that such survivor subsequently elects continuation coverage within the election period, such survivor's (and his or her eligible dependent(s), if applicable) survivor coverage shall be canceled retroactive to the day it commenced.

Survivor coverage for your spouse/domestic partner can continue until he or she dies, cancels survivor coverage or does not make timely premium payments. Survivor coverage can continue if a surviving spouse/domestic partner remarries or enters into a new domestic partner relationship, but the new spouse/domestic partner or any other dependents cannot be added to any Chevron health plan. If your spouse wishes to add his or her new spouse or other dependent to the plan, survivor coverage ends, and up to 36 months of continuation coverage becomes available.

Survivor coverage for your enrolled children can continue until the child reaches age 26 (unless incapacitated), or is no longer eligible according to the eligibility provisions for the health plans for reasons other than your death. Please see the Eligible Children and Other Dependents section for details on eligibility. If your dependent wishes to add his or her new spouse or other dependent to the plan, survivor coverage ends, and up to 36 months of continuation coverage becomes available.

Survivor coverage will also end early if the survivor fails to timely pay any required premiums for coverage or as of the date the survivor has received the maximum benefit under a particular Chevron health plan. Survivor coverage will also end if Chevron ceases to provide any health plan for any of its employees or retirees. Survivor coverage may also be terminated due to fraud or intentional misrepresentation of a material fact.

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

If a surviving spouse/surviving domestic partner or surviving dependent child waives all health plan coverage, they become permanently ineligible for future Chevron health plan coverage with respect to your death.

Additional Rights and Rules

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

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

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

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

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

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

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

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

How Much USERRA Continuation Coverage Costs

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

How to Contact ADP for More Information

If you have any questions about the COBRA law, please contact ADP Benefit Services at 1-888-825-5247 (610-669-8595 outside the U.S.) and select option 2, then " *," then 1. Or, write to ADP Benefit Services at P.O. Box 2638, Alpharetta, GA 30023-2638.

Glossary

After-Tax Contributions
After-tax contributions are withheld from your paycheck after federal and state income taxes are withheld.

Before-Tax Contributions
Before-tax contributions are withheld from your pay first, before taxes are calculated and deducted. So you pay less in taxes. Before-tax contributions aren't subject to federal income taxes, and they aren't subject to state income taxes except in New Jersey and for certain benefits, Pennsylvania. Also, before-tax contributions to health plans, the Health Care Spending Account (HCSA) and the Dependent Day Care Spending Account (DCSA) aren't subject to Social Security taxes (unlike before-tax contributions to 401(k) savings plans).

Before-Tax Contribution Plan
This is a plan that permits you to pay your portion of the monthly costs of any medical, dental, and vision plan coverage with before-tax contributions. If you choose before-tax deductions, you are automatically enrolled in the Before-Tax Contribution Plan. With this plan you are limited in your ability to make enrollment changes in your health plans during the year. Also, if you make contributions on a before-tax basis for medical coverage, you are required to make contributions on a before-tax basis for dental and vision coverage and vice versa.

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.

Coinsurance
A way you share costs of services with the plan. You and the plan split the costs by each paying a specified percentage of covered charges.

Common-Law Employee
A worker who meets the requirements for employment status with Chevron under applicable laws.

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

Corporation
Refers to Chevron Corporation.

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

Former Atlas Employee
A person who otherwise qualifies as an eligible employee and who was employed by Atlas immediately prior to its merger with Chevron Corporation (or was employed by Chevron Northeast Upstream Corporation after the merger and on or before October 1, 2011) and who has not been terminated and rehired by Chevron or its affiliates.

Former Caltex Employee
A person who otherwise qualifies as an eligible employee and who was employed by Caltex immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron or its affiliates.

Former Chevron Employee
A person who otherwise qualifies as an eligible employee and who was employed by Chevron immediately prior to its merger with Texaco Inc. and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

Former Texaco Employee
A person who otherwise qualifies as an eligible employee and who was employed by Texaco Inc. immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

Former Unocal Employee
A person who otherwise qualifies as an eligible employee and who was employed by Unocal immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron since the merger with Unocal.

Health and Welfare Eligibility Service
Your health and welfare eligibility service is used to determine your eligibility for vacation, service awards, Short-Term and Long-Term Disability plans and retiree health care benefits. The following applies to an individual who is an employee on or after January 1, 2012. Different rules apply to an individual who terminated employment prior to January 1, 2012.

Health and welfare eligibility service is generally the period of time you're employed by Chevron or by any other member of the Chevron affiliated group, and may include periods when you're not an eligible employee for U.S. pay and benefits.

Health and welfare eligibility service includes all the time you are on an approved Disability Leave for which you are receiving benefits under the Chevron Long-Term Disability Plan. Under special rules, it may also include the time you are on certain other approved leaves of absence. Special rules apply if you do not timely return to active work with a participating company or if you terminate your employment while on an approved leave of absence. Health and welfare eligibility service may also include the time you have been providing services as a “leased employee” on or after July 1, 2002 to a member of the Chevron affiliated group (at the time the services are performed) and you become an employee after providing service as a leased employee, as determined by Chevron in its sole discretion. If you believe one of these special rules apply to you, contact the HR Service Center for further information.

If you leave Chevron after July 1, 2002, and are rehired within 365 days, your service will include the time you were away. If you’re gone longer than 365 days and you haven’t had a permanent service break as a result of your absence, your service before you left will be added to your service after you’re rehired.

If you left Chevron and were rehired, your service before you left will be added to your service after you’re rehired unless you incurred a Permanent Service Break. If you have service with an acquired company prior to the date of the acquisition of that company by Chevron, special rules may apply — contact the HRSC for more information.

Note on grandfathering rules: The definition of health and welfare service has changed over time, and sometimes it has changed to include additional service that was not previously included. This will not change whether you are subject to a grandfather rule in effect prior to the change. This is because whether an employee meets the conditions to have a grandfather rule apply is determined under the rules in place as of the time the grandfather rule was effective.

HIPAA

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

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

When the child reaches age 26 and periodically thereafter, Chevron Corporation will require you to provide documentation stating that the child continues to be incapacitated. For chronic disabilities, as determined by UnitedHealthcare, you must provide documentation every two years. If the disability is not chronic, UnitedHealthcare will determine how frequently you will need to provide such documentation. For details, please call the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).

Leased Employee

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

Open Enrollment

Typically, open enrollment is held 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.

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

Permanent Service Break (for health and welfare eligibility service)
You will not have a permanent service break if you leave Chevron with more than five years of health and welfare eligibility service. You will, however, have a permanent service break if you leave Chevron before you have five years of health and welfare eligibility service and you're not rehired within five years. If you left employment with Chevron before January 1, 2012, the applicable rules at the time of your termination will apply to whether you had a permanent service break.

Primary Payer
The plan that pays benefits first.

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

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

Secondary Payer
The plan that pays benefits second.

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

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Company Contributions to Medical Coverage

Supplement to the Summary Plan Description (SPD)
Effective January 1, 2014

This supplement generally describes the Chevron Corporation Policy regarding its contribution to the cost of medical coverages that are eligible for a Chevron company contribution. This is not a plan text, a summary plan description or a summary of material modification because the amount of the company contribution and how it is determined is not itself part of a medical plan. Nevertheless, if it should be determined to be part of a medical plan, the Supplement, as modified herein, shall constitute the applicable plan provision and summary plan description. There are no vested rights with respect to Chevron medical plans or any company contributions toward the cost of such medical plans. Rather, Chevron Corporation reserves all rights for any reason and at any time to amend, change or terminate these plans or to change or eliminate the company contribution toward the cost of such plans. Such amendments, changes, terminations or eliminations may be applicable without regard to whether someone previously terminated employment with Chevron or was previously subject to a grandfathering provision. Some benefit plans and policies described in the Supplement may be subject to collective bargaining and, therefore, may not apply to union-represented employees.

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Key Contacts

Benefits Connection Website
The Benefits Connection website provides information about the company contribution to medical coverage.

- **hr2.chevron.com**. Click the **Benefits Connection** link near the top of the page to get started.
- Go to the **Health and Welfare** tab on the top navigation for the current company contribution to your medical coverage.
- Go to the **Retirement Plan** tab on the top navigation for:
  - The date you may be eligible for retiree medical coverage.
  - To access a calculator that will help you project the future percentage of the company contribution to retiree medical coverage.

HR Service Center

- 1-888-825-5247 (Inside the U.S.)
- 610-669-8595 (Outside the U.S.)
- 6 a.m. to 5 p.m., Pacific time (8 a.m. to 7 p.m., Central time)
- Monday through Friday, except on holidays.

Read Summary Plan Descriptions Online
You can find summary plan descriptions, general benefit summaries and information about the medical plans Chevron offers to active employees and retirees on the U.S. Benefits website.

- **hr2.chevron.com**

Company Contributions to Employee Medical Coverage

Chevron Corporation determines the total cost of the various medical plans it offers. In general, Chevron Corporation has an "80/20" cost-sharing approach with respect to such total cost. This means that the company pays approximately 80 percent of that cost, and you pay the remaining 20 percent. With this approach, Chevron typically pays 80 percent of the premium for your health care plan or a set maximum company contribution, whichever is less. The maximum company contribution is based on 80 percent of the total premium of the Medical PPO Option 2. If your plan costs less, Chevron will pay 80 percent of the cost of your plan. If your plan costs more, Chevron will pay up to the maximum contribution.

Example
Here's an example based on family coverage:

Plan Name	2014 Monthly Cost for Family Coverage			Company Contribution Percentage
	Total Premium	Company Contribution	Employee Contribution	
Medical PPO Option 2	$1,585	$1,269	$316	80%
Medical PPO Option 1	$1,709	$1,269	$440	74%
Global Choice Plan	$1,241	$993	$248	80%

Medical PPO Option 2 has a total premium of $1,585. Eighty percent of that total premium is the maximum company contribution for family coverage ($1,269).

As you can see, the Medical PPO Option 1 premium is more than Medical PPO Option 2. Therefore, the company contribution equals the set maximum of $1,269

Based on 80 percent of the total premium for Medical PPO Option 2, here are the maximum monthly contributions for all coverage levels:

Coverage Level	2014 Maximum Monthly Contribution
You Only	$470
You and One Adult	$940
You and Child(ren)	$799
You and Family	$1,269

Company Contributions to Retiree Medical Coverage

If you're an eligible retiree, the company currently continues to share the cost of your medical coverage. In general, to be eligible for retiree medical coverage, you must meet *both* of the following requirements:

- You are at least age 50 with 10 years or more of health and welfare eligibility service.
- At least five years of your total health and welfare eligibility service occurred since your last rehire date.

If you are a retiree not eligible for Medicare, your starting company contribution to retiree medical coverage will be based on the maximum active employee company contribution amount in the calendar year you retire. This amount will be prorated based on the applicable percentage corresponding to your points, as described below. Please note that the cost of retiree medical coverage is greater than the maximum company contribution, so even if you have enough points to receive 100 percent of the company contribution, you will still have to pay for coverage.

The company contribution amount toward retiree medical coverage is different if you are Medicare-eligible when you retire or if you become Medicare-eligible as a retiree. All Medicare-eligible retirees receive the same company contribution amount, regardless of year of retirement. Your actual company contribution amount is prorated based on the applicable percentage corresponding to your points at retirement, as described below.

The base company contribution is determined by the calendar year you separate from the company. If you are subsequently rehired, the company contribution determination will continue to be based on your *first* separation date. Chevron limits future increases to the applicable company contribution to no more than 4 percent each year, applied to the starting or existing company contribution amount.

Company Contribution Amount and Proration of Company Contribution Amount

As indicated above, your applicable starting company contribution amount may be prorated based upon your "points" at retirement. Points represent the sum of your age plus years of health and welfare eligibility service when you leave the company. Each point level corresponds to a percentage, which represents the percentage of the company contribution for which you are eligible. In general, the longer you work, the more points you can accumulate, resulting in a higher percentage and therefore a higher company contribution amount toward retiree medical coverage.

In general, if you retired on or after July 1, 2002, one of the following point scales is used to determine the amount of company contribution you receive:

- The 90-point scale applies to retirees eligible for retiree medical who terminate or retire on or after January 1, 2005, unless a grandfather rule applies to you.

- The 80-point scale applies to retirees eligible for retiree medical who retired between July 1, 2002, and December 31, 2004, and to employees who were age 50 or over with at least 10 years of service on December 31, 2004 (as determined under the applicable rules in effect on December 31, 2004), and who retire after that date, unless a grandfather rule applies to you.

The following chart indicates the company contribution under the 80-point scale and the 90-point scale:

Age Plus Years of Health and Welfare Service Points	Company Contribution Under the:	
	80-Point Scale	90-Point Scale
60	50%	50%
61	52.5%	51%
62	55%	52%
63	57.5%	53%
64	60%	54%
65	62.5%	55%
66	65%	56%
67	67.5%	57%
68	70%	58%
69	72.5%	59%
70	75%	60%
71	77.5%	61%
72	80%	62%
73	82.5%	63%
74	85%	64%
75	87.5%	65%
76	90%	67%
77	92.5%	69%
78	95%	71%
79	97.5%	73%
80	100%	75%
81		77%
82		79%
83		81%
84		83%
85		85%
86		88%
87		91%
88		94%
89		97%
90		100%

Grandfather Rules

There are some exceptions to the company contribution amount you may receive. Some retirees are eligible for retiree health care coverage at 100 percent of the maximum company contribution under the rules of former Chevron, former Texaco or former Unocal plans. In these cases, retirees have been protected, or grandfathered, under old or alternate rules. These grandfather rules are described below:

- A former Chevron employee is a person who otherwise qualifies as an eligible employee and who was employed by Chevron immediately prior to its merger with Texaco Inc. and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

- A former Texaco employee is a person who otherwise qualifies as an eligible employee and who was employed by Texaco Inc. immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

- A former Unocal employee is a person who otherwise qualifies as an eligible employee, who was employed by Unocal immediately prior to its merger with Chevron Corporation, and who has not been terminated and rehired by Chevron since the merger with Unocal.

- Whether an employee meets the conditions to have a grandfather rule (including the 80-point scale) apply is determined under the rules in place as of the time the grandfather rule became effective. For example, a change to the health and welfare eligibility service, effective January 1, 2012, does not affect the amount of service the employee had on December 31, 2004 for purposes of whether the 80-point scale applies. (However, if the 80-point scale applies to an employee without regard to the additional service, the additional service would count toward the employee's points on the 80-point scale).

If you're a former Chevron, or former Caltex or former Texaco employee and meet one of the following grandfathering requirements, you receive 100 percent of the company's contribution toward your medical coverage when you retire, subject to the 4 percent limit on future increases to the company contribution:

- You're a former Chevron or former Caltex employee employed by the company on June 30, 2002, and you meet all of the following criteria:

    - You must have had at least 20 years of continuous service or 65 points (age plus years of continuous service) on June 30, 2002, (as determined under the applicable rules in effect on June 30, 2002).

    - You have at least 25 years of health and welfare eligibility service or at least 75 points (age plus years of health and welfare eligibility service) when you retire.

    - You have not been rehired since July 1, 2002.

- You're a former Texaco employee employed by the company on June 30, 2002, and on October 1, 1999, you were a Texaco employee who was age 45 or older and you retire at age 55 or older with at least 10 years of health and welfare eligibility service.

If you're a former Unocal employee employed by the company on June 30, 2006, you may be eligible for a company contribution percentage based on the grandfathered Unocal transition scale. If you retire on or after July 1, 2006, at age 55 or older with 10 or more years of health and welfare eligibility service, and you meet the age and service requirements by December 31, 2007, (as determined under the applicable rules in effect on December 31, 2007), you will be eligible for the *greater* (that is, the greater company contribution percentage) of the Chevron 90-point scale or the grandfathered Unocal transition scale shown below:

Grandfathered Unocal Transition Scale

Years of Service After Age 35	Company Contribution Percentage
10	50.0%
11	55.0%
12	60.0%
13	65.0%
14	70.0%
15	75.0%
16	80.0%
17	85.0%
18	90.0%
19	95.0%
20	100.0%

Rehired Retirees Who Subsequently Retire a Second Time

If you retire from Chevron having met eligibility requirements for retiree medical coverage under any applicable eligibility rule at the time you retire, and you subsequently are rehired and then retire again, you are eligible for the better of the corresponding company contribution to retiree medical coverage based on the date you first retired (as in effect at the time of your second retirement) and any subsequent eligibility for retiree medical for which you qualify, taking into account your second period of employment.

Examples: How Points and Company Contributions Amounts Are Determined with Respect to Retiree Medical Coverage

Here are some examples to help you understand how points and company contribution amounts are determined. These examples assume that the individuals qualify for retiree medical coverage. **They are estimates in which the age, service and points are rounded for purposes of the illustration only.** Actual age plus years of service point calculations performed by the HR Service Center upon an employee's retirement extend to four decimal points, and service is currently counted until the end of the month in which the employee terminates Chevron employment.

Chris, a Chevron employee retiring under the new 90-point scale

Chris is 36 years old with seven years of service.

Chris' points

Chris has 43 age plus years of service points (36 years old plus seven years of service). Chris is not eligible for retiree medical coverage because he is not 50 years old with 10 years of service. When Chris turns 50, he will have 71 age plus years of service points, making him eligible for 61 percent of the maximum applicable company contribution for retiree medical coverage. Because Chris is not eligible for any grandfathering, he will need 90 points to qualify for 100 percent of the applicable company contribution for retiree medical coverage.

Chris' eligibility for the 100 percent company contribution

When Chris has 90 age plus years of service points he will be eligible for 100 percent of the applicable company contribution for retiree medical coverage.

Pat, a Chevron employee grandfathered under the 80-point scale

Pat is grandfathered under the grandfathering provision — age 50 or older with 10 years of service on December 31, 2004. Pat is 56 years old with 16 years of service.

Pat's points

Pat has 72 age plus years of service points (56 years old plus 16 years of service), making her eligible for 80 percent of the applicable company contribution for retiree medical coverage.

Pat's eligibility for the 100 percent company contribution

Pat will be eligible for 100 percent of the applicable company contribution for retiree medical coverage when she earns 80 age plus years of service points.

Robert, a former Chevron employee

Robert is a former Chevron employee, grandfathered under former Chevron rules. Robert is 58 years old with 28 years of service.

Robert's points

Robert has 86 age plus years of service points. Robert is grandfathered under the former Chevron rule because he had at least 20 years of continuous service or 65 points on June 30, 2002, and when he retires he will have at least 25 years of health and eligibility service or at least 75 points.

Robert's eligibility for 100 percent of the applicable company contribution

Because he was eligible for the grandfather rule, Robert currently is eligible for 100 percent of the applicable company contribution.

Maria, a former Texaco employee

Maria is a former Texaco employee, grandfathered under the former Texaco rules, who was age 45 or older on October 1, 1999. Maria is 60 years old with 16 years of service.

Maria's points

Maria has 76 points. However, Maria should not refer to the 80-point scale to determine her percentage of company contribution since she already meets the former Texaco grandfather rules as noted below.

Maria's eligibility for 100 percent of the applicable company contribution

Because she was age 45 or older as of October 1, 1999, and will be retiring at age 55 or older with 10 years of health and welfare eligibility service, Maria is currently eligible to retire with 100 percent of the applicable company contribution.

Terry, a former Unocal employee

Terry is a former Unocal employee who wants to retire and who is 59 years old with 26 years of service. He will have 85 points (59 + 26) under the Chevron 90-point scale — equivalent to a company contribution percentage of 85 percent of the starting maximum company contribution amount for this year. However, Terry meets the requirements of the grandfathered Unocal transition scale (the Unocal transition scale gives him 100 percent of the applicable company contribution).

Terry's eligibility for 100 percent of the applicable company contribution

Terry meets the age and service requirement for eligibility under the grandfathered Unocal transition scale because he had 20-plus years of service after age 35 on December 31, 2007. According to the Unocal transition scale, this service is equivalent to 100 percent of the applicable company contribution. The greater amount (100 percent) will be applied against the total cost of retiree coverage.

Mike, a former Unocal employee

Mike is a former Unocal employee who wants to retire. As of December 31, 2007, he was age 54 with 20 years of service. He does not meet the eligibility requirements for the grandfathered Unocal transition scale because he did not satisfy the age and service requirements by December 31, 2007. Therefore, when he retires, he will be eligible for the Chevron 90-point scale.

Mike's eligibility for 100 percent of the applicable company contribution

Mike will be eligible for 100 percent of the applicable company contribution for retiree medical coverage when he earns 90 age plus years of service points.

About Health and Welfare Eligibility Service

Definition of Health and Welfare Eligibility Service

Your health and welfare eligibility service is used to determine your eligibility for vacation, service awards, Short-Term and Long-Term Disability plans and retiree health care benefits. The following applies to an individual who is an employee on or after January 1, 2012. Different rules apply to an individual who terminated employment prior to January 1, 2012.

Health and welfare eligibility service is generally the period of time you're employed by Chevron or by any other member of the Chevron affiliated group, and may include periods when you're not an eligible employee for U.S. pay and benefits.

Health and welfare eligibility service includes all the time you are on an approved Disability Leave for which you are receiving benefits under the Chevron Long-Term Disability Plan. Under special rules, it may also include the time you are on certain other approved leaves of absence. Special rules apply if you do not timely return to active work with a participating company or if you terminate your employment while on an approved leave of absence. Health and welfare eligibility service may also include the time you have been providing services as a “leased employee” on or after July 1, 2002 to a member of the Chevron affiliated group (at the time the services are performed) and you become an employee after providing service as a leased employee, as determined by Chevron Corporation in its sole discretion. If you believe one of these special rules apply to you, contact the HR Service Center for further information.

If you leave Chevron after July 1, 2002, and are rehired within 365 days, your service will include the time you were away. If you’re gone longer than 365 days and you haven’t had a permanent service break as a result of your absence, your service before you left will be added to your service after you’re rehired.

If you left Chevron and were rehired, your service before you left will be added to your service after you’re rehired unless you incurred a Permanent Service Break. If you have service with an acquired company prior to the date of the acquisition of that company by Chevron, special rules may apply — contact the HR Service Center for more information.

Note on grandfathering rules: The definition of health and welfare eligibility service has changed over time, and sometimes it has changed to include additional service that was not previously included. This will not change whether you are subject to a grandfather rule in effect prior to the change. This is because whether an employee meets the conditions to have a grandfather rule apply is determined under the rules in place as of the time the grandfather rule was effective.

Definition of a Permanent Service Break

You will not have a permanent service break if you leave Chevron with more than five years of health and welfare eligibility service. You will, however, have a permanent service break if you leave Chevron before you have five years of health and welfare eligibility service and you’re not rehired within five years. If you left employment with Chevron before January 1, 2012, the applicable rules at the time of your termination will apply to whether you had a permanent service break.

Glossary

Former Atlas Employee
A person who otherwise qualifies as an eligible employee and who was employed by Atlas immediately prior to its merger with Chevron Corporation (or was employed by Chevron Northeast Upstream Corporation after the merger and on or before October 1, 2011) and who has not been terminated and rehired by Chevron or its affiliates.

Former Caltex Employee
A person who otherwise qualifies as an eligible employee and who was employed by Caltex immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron or its affiliates.

Former Chevron Employee
A person who otherwise qualifies as an eligible employee and who was employed by Chevron immediately prior to its merger with Texaco Inc. and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

Former Texaco Employee
A person who otherwise qualifies as an eligible employee and who was employed by Texaco Inc. immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

Former Unocal Employee
A person who otherwise qualifies as an eligible employee and who was employed by Unocal immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron since the merger with Unocal.