

Human Energy. Yours.™



# **Your Chevron Benefits**

For Retirees

Summary Plan Description (SPD)

Effective January 1, 2014

The information contained in this booklet satisfies the summary plan description requirements provided under the Employee Retirement Income Security Act of 1974 (ERISA). These descriptions don't cover every provision of the plans. Many complex concepts have been simplified or omitted in order to present more understandable plan descriptions. If these 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. Chevron is the plan administrator of the plans described in this booklet. Chevron, in its sole discretion, has the authority to interpret these plans, and it may adopt rules and procedures to implement any plan provision. Chevron also has the authority to take any appropriate action to administer these plans. Subject to the plans' review procedures, Chevron's decisions about these plans are conclusive and binding on all persons.

Your right to receive benefits under the plans described in this booklet is determined by the official plan text — not by the information in this booklet or by any other written or oral communication you may receive from the plan administrator, from the claims administrator or from Chevron.

**As you read this booklet, you'll notice that it refers to "you" and "your" when discussing benefits. This doesn't mean that everyone who reads this booklet is eligible to participate in the benefit plans described here or is qualified to receive benefits that might be payable by the plans. You should carefully read the descriptions of the plans to find out when and how you can qualify to receive plan benefits.**

**If You Retired or Left Chevron or One of Its Predecessor Companies Before July 1, 2002**

This booklet mainly describes benefit plans in effect for those who left Chevron on or after July 1, 2002. If, before July 1, 2002, you retired or left Chevron, Texaco, Gulf, Getty, Caltex, Amoseas, or another company that merged into Chevron or Texaco, other benefit plan provisions may apply to you. For the most part, if you were considered a retiree or survivor with eligibility for health care benefits as of June 30, 2002, then you also are eligible for at least some or all of the benefit plans described in this booklet.

**If You Retired From Unocal Before July 1, 2006**

This booklet mainly describes benefit plans in effect for former Unocal participants who left Chevron on or after July 1, 2006. If you are a former Unocal employee and you retired or left Chevron before July 1, 2006, other benefit plan provisions may apply to you. For the most part, if you were considered a retiree or survivor with eligibility for health care benefits as of June 30, 2006, then you also are eligible for at least some or all of the benefit plans described in this booklet.

Please contact the HR Service Center to obtain information that describes your benefit eligibility and coverages.

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# Key Chevron Benefit Resources

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## Human Resources (HR) Service Center

If you have questions regarding your plan options, eligibility and enrollment, please call the HR Service Center.

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

## Chevron Benefits Website on the Internet

You can access the Chevron benefits website on the Internet. You can access summary plan descriptions, other benefit information and links to other key benefit phone numbers and websites, such as Benefits Connection and Vanguard.

- [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree)

## 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 “ \* ”

## Express Scripts

Prescription drug coverage

Medical PPO, Medicare Plus Plan, Medicare Standard Plan, Chevron Senior Care Plan

- [www.Express-Scripts.com](http://www.Express-Scripts.com)
- 1-800-987-8368 (non-Medicare)
- 1-800-935-6215 (Medicare)

## Medical and Dental HMO Plans

If you choose medical or dental HMO coverage, the insurer and claims 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 Chevron HR Service Center (see above).
- Or get your plan's information on the Chevron benefits website on the Internet (see above).

## **MetLife**

Basic Life Insurance Plan (Former Chevron Employees)  
Term Life Insurance Plan of Texaco, Inc. (Former Texaco Employees)  
Unocal Life Insurance Plan (Former Unocal Employees)

- 1-800-638-6420
- 5 a.m. to 5 p.m. Pacific time, Monday through Friday

## **United Concordia Companies, Inc. (UCCI)**

Dental PPO Plan

- [www.ucci.com](http://www.ucci.com)
- 1-877-424-3876

## **UnitedHealthcare**

Medical coverage  
Medical PPO, Medicare Plus Plan, Medicare Standard Plan, Chevron Senior Care Plan

- [www.myuhc.com](http://www.myuhc.com)
- 1-800-654-0079

## **ValueOptions or EAP-WorkLife Services**

Mental Health and Substance Abuse Plan

- [www.valueoptions.com](http://www.valueoptions.com)
- ValueOptions: 1-800-847-2438

## **VSP Vision Services**

Basic vision coverage  
Medical PPO, Medicare Plus Plan, Medicare Standard Plan, Chevron Senior Care Plan

- [www.vsp.com/go/chevron](http://www.vsp.com/go/chevron)
- 1-800-877-7195 (Inside the U.S.)
- 916-851-5000 (Outside the U.S.) Press "0" for operator assistance.



# Update to the Summary Plan Description Effective January 1, 2017

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

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

You can access the summary plan descriptions for your benefits on the Internet at [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) 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 Mental Health and Substance Abuse Plan (MHSA) Summary Plan Description** (both the SPD posted online and the Your Chevron Retiree Health Benefits Summary Plan Description for retirees compilation available in print.)

## What the Plan Pays Chapter Mental Health Benefit Section

The following applies to the **Emergency Treatment** table. This information replaces the current information in that table.

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### Emergency Treatment

---

**U.S. Network**

The plan pays 90% of contracted fees after 10% coinsurance (\$250 maximum).

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**U.S. Out-of-Network**

The plan pays 90% of allowed charges after 10% coinsurance (\$250 maximum).

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## What the Plan Pays Chapter Substance Abuse Benefits Section

The following applies to the **Emergency Treatment** table. This information replaces the current information in that table.

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### Emergency Treatment

---

**U.S. Network**

The plan pays 90% of contracted fees after 10% coinsurance (\$250 maximum).

---

**U.S. Out-of-Network**

The plan pays 90% of allowed charges after 10% coinsurance (\$250 maximum).

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# Update to the Summary Plan Description

## Effective January 1, 2017

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You can access the summary plan descriptions for your benefits on the Internet at [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) 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 Your Chevron Benefits in Retirement Summary Plan Description** (both the SPD posted online and the SPD available in print.)

# contents

As recently announced in August, Chevron is changing the way you access and enroll in retiree medical and prescription drug plan coverage effective January 1, 2017. This newsletter provides more detailed information about the changes announced for both pre-65 retirees and post-65 retirees, including additional information and updates available since the August communication. It also includes open enrollment instructions for pre-65 eligible retirees and pre-65 eligible dependents.

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**Summary of Benefits and Coverage (SBCs)** provide summary information about your pre-65 health plans, such as benefits, copayments, deductibles, coinsurance and plan contact information. SBCs can help you understand the key differences among the options available to you. **Summary Plan Descriptions (SPDs)** provide specific details about your Chevron benefits, such as eligibility and covered services. You can get your SBCs and SPDs in two ways:

- **Online.** SBCs and SPDs are available free of charge online at [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree).
- **By phone.** To request a printed free copy by mail, contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.) and select option 2.

Page 9-51 of this newsletter serve as an official summary of material modification (SMM) to the summary plan description (SPD) book(s) for the plans referenced herein. Please keep this information with your other plan documents for future reference. This SMM provides only certain information about changes of benefit provisions. It is not intended to be a complete explanation. If there are any discrepancies between this SMM 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. Summary plan descriptions (SPDs) provide detailed information about your Chevron benefit plans such as eligibility, claims and participation. You can get your SPDs in two ways: visit [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) and choose the **Your Benefits** tab; call the HR Service Center to request a free printed copy by mail at 1-888-825-5247 (inside the U.S.) or 610-669-8595 (outside the U.S.), and select option 2.

# updates for all retirees

new information since the last august communication

## retiree medical enrollment milestone updates

In the August 2016 newsletter, *Changes to the Retiree Medical Program*, we announced new rules for enrolling yourself and your eligible dependents in the health coverage offered to Chevron retirees. Be sure to review the **Enrollment Milestones** section (Page 47) of this newsletter for important updates including:

- We have **expanded some of the enrollment milestone opportunities** since the August communication. For example, there are now opportunities to return to the coverage offered to Chevron eligible retirees after losing employer group health coverage *regardless of your age*.
- Details about **when you can enroll eligible dependents** and if you can add eligible dependents at a later date. This information was not covered in the August communication.
- Effective January 1, 2017, post-65 eligible retirees and/or their post-65 eligible dependents will receive the company contribution in a new way, through a Health Reimbursement Arrangement, or HRA. The rules regarding eligibility to receive the HRA *have not* changed since the August communication.

## how was my health reimbursement arrangement (HRA) amount calculated?

If you or an eligible dependent are eligible to receive the 2017 Chevron company contribution to retiree health coverage through the new health reimbursement arrangement (HRA) with OneExchange, a personalized letter with the designated HRA amount for each eligible participant was included in the August *Getting Started* package from OneExchange.

The fundamental way in which your company contribution is determined has not changed. In 2017, Chevron is contributing the same total amount toward post-65 retiree medical (and dental, if applicable) coverage that was contributed in 2016. The only change is the way the contribution is delivered, through the HRA.

Your applicable **starting company contribution amount** is 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 starting company contribution** amount for which you are eligible.

- The **points** you had when you left Chevron have not changed.
- The **point scale** for which you are eligible has not changed.

How the **starting company contribution** to retiree medical (and dental, if applicable) is determined has not changed. Keep in mind that the starting company contribution is *different* for Medicare-eligible (post-65) participants and not Medicare-eligible (pre-65) participants. *If you have a mixture of pre-65 and post-65 eligible participants in your family, this is why the company contribution amount may appear to be different in 2017 than on your previous coverage statements from the HR Service Center.*

- **For pre-65 (not Medicare-eligible):** Your starting company contribution to retiree medical coverage will be based on the maximum active employee company contribution amount in the calendar year you retired. This amount will be prorated based on the applicable percentage corresponding to your points at retirement.
- **For post-65 (Medicare-eligible):** Most Medicare-eligible retirees have the same starting company contribution amount, regardless of year of retirement.\* This amount will be prorated based on the applicable percentage corresponding to your points at retirement.

*\*There may be a different amount for certain legacy company retirees or other grandfathered groups.*

<b>Post-65 Company Contribution Formula</b>		<b>Sample Calculation</b> This is an example only. Your numbers may be different based on your situation.
<b>\$</b>	Starting post-65 company contribution amount to retiree medical.	Starting post-65 company contribution for sample retiree. <b>\$96.20</b>
<b>times %</b>	Times the percentage of the company contribution for which you are eligible, based on your points at retirement and the point scale for which you are eligible.	For a retiree eligible for the maximum company contribution. <b>X 100%</b>
<b>minus \$6.28</b>	Minus allocation to the Chevron Supplemental Catastrophic Prescription Drug Benefit. This is a flat rate for all eligible participants.	This is a flat rate for all post-65 participants. <b>- \$6.28</b>
<b>equals \$</b>	Equals Chevron's contribution to the health reimbursement arrangement (HRA) for post-65 eligible participants.	Retiree medical amount deposited to HRA each month for this sample retiree and all post-65 eligible dependents in the family. <b>\$89.92</b>
<b>plus \$4.50</b>	Chevron's contribution to the health reimbursement arrangement (HRA) for post-65 eligible participants eligible for retiree dental coverage. This is a flat rate for all eligible participants.	Sample retiree's monthly HRA amount with the dental contribution included. <b>\$94.42</b>



## billing transition for post-65 health coverage

If you or an eligible dependent will participate in the individual health coverage offered to post-65 participants through OneExchange, here is information about the transition of your 2017 monthly premium payments. *If you or an eligible dependent are pre-65, there is no change to the way you will pay for your pre-65 Chevron group health coverage. The information below doesn't apply to pre-65 premium payments.*

### Direct Debit

HR Service Center currently withdraws your monthly premium payments directly from your bank account.

### Last withdrawal for post-65 health coverage in mid-November 2016 (For December 2016 premium)

After this final withdrawal, direct debit will automatically stop. No further action is required from you. Direct debit for pre-65 health coverage will automatically continue if you or an eligible dependent are enrolled in pre-65 health coverage. If you continue retiree life insurance coverage (if applicable), direct debit for this coverage will also continue. Your December 2016 withdrawal (for January 2017 premium) will be adjusted to reflect the new amount.

### Direct Bill

HR Service Center currently mails a paper bill for your monthly premium payments.

### Last bill for post-65 health coverage mailed in early November 2016 (Due December 1, 2016)

After this final bill, paper billing for post-65 health coverage will automatically stop. No further action is required from you, but if you have automatic bill pay set up with your personal bank account, you may need to take action to cancel or adjust those payments after the November bill has been paid. Direct bill for pre-65 health coverage will automatically continue if you or an eligible dependent are enrolled in pre-65 health coverage. If you continue retiree life insurance coverage (if applicable), direct bill for this coverage will also continue. Your December 2016 (for January 2017 premium) will be adjusted to reflect the new amount.

### Pension Deduction

HR Service Center currently deducts your monthly premium from your Chevron Retirement Plan annuity payment.

### Last annuity payment reflecting a deduction for post-65 health coverage is on December 23, 2016 (For December 2016 premium)

After the December 23 annuity payment, pension deductions for post-65 health coverage will automatically stop. No further action is required from you. Pension deductions for pre-65 health coverage will automatically continue if you or an eligible dependent are enrolled in pre-65 health coverage. If you continue retiree life insurance coverage (if applicable), pension deductions for this coverage will also continue. Your January 2017 pension deduction will be adjusted to reflect the new amount.

## paying for 2017 post-65 health coverage premiums

Starting in 2017, you will pay your health premium(s) directly to your insurance carrier(s). How you pay the premium to the carrier(s) — either by check, credit card, or direct debit from your checking — and how often you pay (monthly, quarterly, annually) varies by insurance company. You will receive plan information from your new carrier after you enroll, including information about how to arrange the type of payment and the frequency directly with the insurance carrier(s). Note that some carriers may require an initial payment at the time you enroll.

In October you'll receive an **Enrollment Guide** package from OneExchange that includes a quick reference guide — **HRA Payment and Reimbursement Overview** — with more information about how you'll pay for post-65 health coverage in 2017 and what you need to do to be reimbursed from your Health Reimbursement Arrangement (HRA) for those premiums, if applicable. While you'll pay the insurance carrier(s) directly for coverage, OneExchange is the claims administrator of your HRA and will provide you with reimbursement for your payment of eligible plan premiums. Watch for your enrollment package from OneExchange to learn more.

## paying for 2017 pre-65 health coverage premiums

If this is your first time to participate in the health coverage offered to pre-65 Chevron eligible retirees and pre-65 eligible dependents, you'll choose the method for paying monthly 2017 health coverage premiums when you enroll. Payments for 2017 pre-65 health coverage will be made to the HR Service Center. Payment options include direct debit from your bank account, direct bill in which you receive a paper bill each month, or a deduction taken from your Chevron Retirement Plan annuity payment (if applicable). More information and instructions are provided when you enroll.

# how to enroll in pre-65 chevron group health coverage

october 17 through october 28, 2016

**The Chevron open enrollment period is the time that you can enroll in or make changes to your 2017 Chevron retiree group health coverage for pre-65 eligible participants. The enrollment instructions here apply to pre-65 eligible participants only.** Post-65 eligible participants will make enrollment choices through OneExchange, and the deadline to act is different (see Page 8). If you have not already done so, contact a OneExchange benefit advisor now to set up a post-65 enrollment appointment. Call 1-844-266-1392 (1-801-994-9805 outside the U.S.).

If you're **currently participating** and are eligible to continue participating in pre-65 Chevron group health coverage, you can keep the coverage you currently have, or you can make changes, such as switching to another plan (if available) or adding an eligible dependent to your coverage. If you don't make changes by October 28, you generally can't make any changes until the next enrollment period in the fall of 2017 for 2018 benefits. However, you can make changes outside of the open enrollment period, provided that you do so within the 31-day deadline after a qualifying life event, and as long as you and your eligible dependent continue to meet eligibility requirements and both you and your eligible dependent are under age 65. See Page 42 for more retiree health coverage enrollment rules.

If you **aren't currently participating** in Chevron pre-65 group health coverage, this is your opportunity to enroll. If you miss the October 28 enrollment deadline, you must wait until the next applicable milestone to enroll in the health coverage offered to Chevron retirees; you will not be able to enroll during open enrollment in the fall of 2017 for 2018 benefits. See Page 42 for more retiree health coverage enrollment rules.



## online

Make your pre-65 elections online up until midnight Pacific time on October 28.

- Go to [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree).
- Choose **Open Enrollment** to get started.



## by phone

Customer Service Representatives can take your pre-65 open enrollment elections by phone until 5 p.m., Pacific time (7 p.m., Central time) on October 28.

### HR Service Center

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

### Representatives Available

Monday through Friday  
6 a.m. to 5 p.m. Pacific time  
8 a.m. to 7 p.m. Central time

For quicker service, avoid peak call hours. Peak hours are all day Monday and 9 a.m. to 10 a.m. Pacific time (11 a.m. to noon Central time) on other weekdays.

# enrollment deadlines

If you're an eligible retiree and are not currently enrolled in Chevron retiree health coverage, or if you need to enroll eligible dependents not currently covered, you have a one-time enrollment opportunity this fall. If you miss the enrollment deadline, you must wait until the next applicable milestone to enroll. See Page 42 to be sure you understand the enrollment milestones for you and your eligible dependents.

## Pre-65 eligible retirees and pre-65 eligible dependents

**October 17 – October 28, 2016**

**Enrollment for pre-65 health plans will occur during Chevron's open enrollment period.**

- You'll also receive a personalized enrollment worksheet under separate cover from the Chevron Human Resources Service Center. This worksheet lists the health plans available and the 2017 cost for coverage.
- Elections will be conducted on the **Benefits Connection** enrollment website or by calling the **Chevron Human Resources Service Center**.

## Post-65 eligible retirees and post-65 eligible dependents

**Enrollment for post-65 individual health plans will occur through OneExchange according to the two timelines listed below.**

Coverage to take effect on January 1, 2017.

- Enrollment information was sent from OneExchange in August to all post-65 eligible participants.
- Elections will be conducted by phone with a OneExchange benefit advisor.

**October 3 through December 31, 2016**

Currently enrolled in a Chevron medical plan.

**October 15 through December 7, 2016**

Currently *not enrolled* in a Chevron medical plan.

Contact a OneExchange benefit advisor now to set up your enrollment appointment. Call 1-844-266-1392 (1-801-994-9805 outside



# pre-65 medical plan changes

for eligible retirees and eligible dependents under age 65  
changes to your benefits that take effect january 1, 2017



# meet anthem blue cross

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

## what's staying the same

### Plan coverage

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

### Prescription drug, basic vision, mental health and substance abuse coverage

The move to Anthem only affects your medical coverage.

- **Express Scripts** will continue to be the claims administrator for your prescription drug plan.
- If you are enrolled in the Medical PPO Plan, the HDHP or the HDHP Basic, you're automatically enrolled in the Vision Program for basic vision coverage. **VSP Vision Care** (VSP) will continue to be the claims administrator for this coverage.
- If you are enrolled in the Medical PPO Plan, the HDHP or the HDHP Basic, you're automatically enrolled in the Mental Health and Substance Abuse (MHSA) Plan, so long as you are not eligible for Medicare. **Beacon Health Options** (Beacon) will continue to be the claims administrator.

### Eligibility rules

Who is covered, and who you can cover — the eligibility rules for pre-65 eligible retirees and their pre-65 eligible dependents — are the same. However, all benefits-eligible retirees must enroll in Chevron retiree health coverage upon reaching certain milestones, and you must also enroll your eligible dependents at certain milestones. If you miss these select opportunities to enroll, you and your eligible dependents will not be permitted to return to Chevron retiree health coverage in the future. (See Page 47.)

### Preventive care

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

### Out-of-pocket maximum protection

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

## what's changing

### Who to contact

There are new phone numbers and website addresses for the claims administrator of your medical services. See Page 52.

### Provider network for medical services

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

### New member number and medical ID card

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

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

### Claim form for medical services

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

## Do I need to find a new doctor?

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

## continuation of care

Remember, the Medical PPO, HDHP and HDHP Basic are preferred provider organization plans, so you can continue to use any provider you choose, network or out-of-network. However, the deductible and out-of-pocket amounts are lower when you see a network provider. Continuation of care allows you to continue to receive care for certain conditions from providers who do not participate in the Anthem network. You might need continuation of care if you are already in active treatment for certain ongoing conditions on January 1, 2017. Examples of conditions eligible for transition of care might include:

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

To qualify for this continuation of care benefit, you must apply for it by March 1, 2017. The application form is available on [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) (click on **2017 Benefit Changes**) and is also available by calling Anthem (see Page 52). A letter will be sent to you outlining the decision or requesting additional information, if needed. You can contact Anthem to confirm if your request has been received.



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

### **Do I need to get a new prescription?**

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

### **claims for medical services**

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

#### **Submit 2016 claims to UnitedHealthcare by June 30, 2017**

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

#### **How to submit 2017 claims to Anthem Blue Cross**

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



## anthem website

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

- Go to [anthem.com/ca](http://anthem.com/ca) starting January 1, 2017.
- Click **Register Now** and follow the instructions on the screen.

## anthem anywhere mobile app

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

With the app you can:

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



### Find a provider

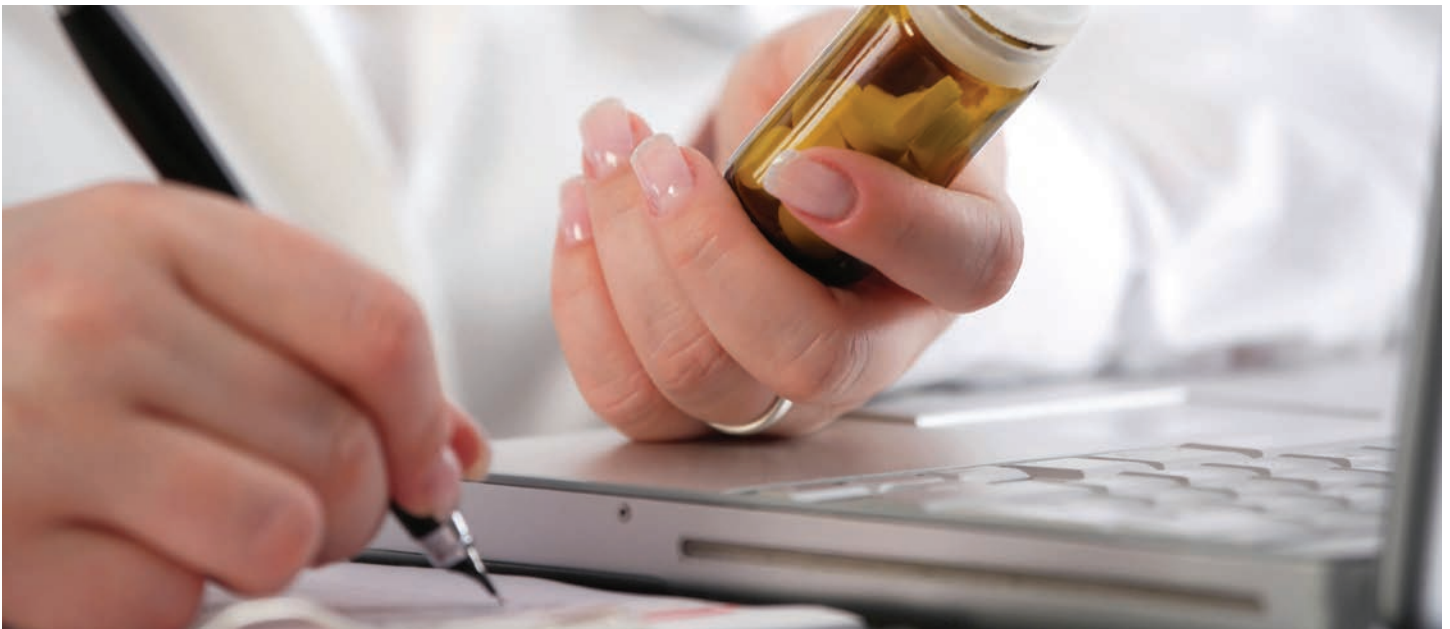
Go to [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) and click on **2017 Benefit Changes** to access special links that make it easier to research your provider options.

# prescription drug program

If you are enrolled in the Medical PPO Plan, the High Deductible Health Plan (HDHP) or the new High Deductible Health Plan Basic (HDHP Basic), you automatically have prescription drug coverage through the Prescription Drug Program with Express Scripts. The Prescription Drug Program currently has prior authorization, preferred step therapy and drug quantity management programs in place, but these programs will be expanding in 2017. This is an administrative change only; you don't need to do anything as a result of this change.

- The Prescription Drug Program covers some drugs only if they're prescribed for certain uses (or only up to certain quantity levels). For this reason, some medications will require your prescribing doctor to provide additional clinical information so that use of the medication can be approved in advance before you can receive Prescription Drug Program benefits. This is called **prior authorization**.
- Certain drugs are covered by the Prescription Drug Program only if preferred drugs — which include generics — are tried first. This is called **Preferred Step Therapy**. If your medication is subject to Preferred Step Therapy, this means that you will be required, when clinically appropriate, to try a preferred drug before Express Scripts will authorize coverage for the use of non-preferred drugs.
- **Drug Quantity Management** is a program included in the Prescription Drug Program that's designed to make the use of prescription drugs safer and more affordable. It provides you with medicines you need for your good health and the health of your covered dependents, while making sure you receive them in the amount — or quantity — considered safe and most cost effective.

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



# medical PPO plan

Aside from the switch to a new claims administrator — Anthem Blue Cross — this section provides more detail about other changes to the Chevron Medical PPO Plan that will be offered to pre-65 eligible retirees and their pre-65 eligible dependents effective January 1, 2017.

## New monthly premium cost

Chevron will currently continue to share the monthly cost of coverage — the premium — with you. The HR Service Center will mail a personalized open enrollment worksheet to you under separate cover in early October. The worksheet includes the 2017 cost for coverage for pre-65 eligible participants. Chevron's company contribution to retiree medical coverage for all non-Medicare medical plans for 2017 will remain the same amount as for 2016.

## prescription drug program

If you are enrolled in the Medical PPO Plan, you automatically have prescription drug coverage through the Prescription Drug Program with Express Scripts. See Page 14 for information about the 2017 Prescription Drug Program.

## medical PPO option 1 no longer offered

The Chevron Medical PPO Plan will be streamlined. The **Medical PPO Option 1** will no longer be offered effective January 1, 2017. The current Medical PPO Option 2 will still be offered at this time, but it will just be referred to as the **Chevron Medical PPO Plan**. You'll continue to have the flexibility to see whichever provider you'd like — network or out-of-network.

- If you are **currently enrolled in the Medical PPO Plan — Option 1**, you will be automatically enrolled in the Medical PPO Plan effective January 1, 2017. You do not have to make an enrollment election during open enrollment, unless you want to make a change to your coverage or choose another plan.
- If you are **currently enrolled in the Medical PPO Plan — Option 2**, you will automatically continue to be enrolled in the Medical PPO Plan effective January 1, 2017. You do not have to make an enrollment election during open enrollment, unless you want to make a change to your coverage or choose another plan.



## Find a provider


Go to [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) and click on **2017 Benefit Changes** to access special links that make it easier to research your provider options.

## new annual deductibles

The Medical PPO Plan has separate deductibles, one for **medical** services and the other for **prescription drug costs**. There is no deductible for **mental health** and **substance abuse** services. Effective January 1, 2017, the following changes to the Medical PPO deductibles will take effect.

### Covered medical services


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

	Coverage Category	Network	Out-of-Network
	You only	\$1,000	\$2,000
	You + One adult	\$2,000	\$4,000
	You + Child(ren)	\$2,000	\$4,000
	You + Family	\$3,000	\$6,000

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

### Covered prescription drugs

The prescription drug deductible will change in 2017, and the deductible amount is the same whether you use a network or out-of-network provider. Deductible does not apply to mail-order prescriptions.

	Coverage Category	
	You only	\$400
	You + One adult	\$800
	You + Child(ren)	\$800
	You + Family	\$800

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

### Covered mental health and substance abuse services

If you and any of your covered dependents are enrolled in the Medical PPO Plan, you are also automatically enrolled in the Chevron Mental Health and Substance Abuse (MHSA) Plan, so long as you aren't eligible for Medicare.



The deductible does not apply to mental health and substance abuse services, network or out-of-network.

## new out-of-pocket maximums

The Medical PPO has separate out-of-pocket maximums, one for **prescription drug costs** and the other for **medical, mental health and substance abuse services, combined**.

### Covered prescription drugs

The prescription drug out-of-pocket maximum will not change in 2017, and the amount is the same whether you use a network or out-of-network provider.





Individual	\$1,800
Family	\$3,600

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

### Covered medical, mental health and substance abuse services, combined

There are different out-of-pocket maximums for **medical, mental health and substance abuse** services combined, depending on if you see a network provider or an out-of-network provider. These out-of-pocket amounts will increase in 2017 for this plan. *Note:* While covered mental health and substance abuse services will apply to the combined out-of-pocket maximum, know that, depending on your usage, you may actually reach the MHSA Plan's out-of-pocket maximum for covered mental health and substance abuse services *before* you reach the Medical PPO Plan's combined annual out-of-pocket maximum amount. See Page 30 for more information about the MHSA out-of-pocket maximum amount. Amounts paid for covered services provided by a network provider also count toward the out-of-network maximum. Amounts paid for covered services provided by an out-of-network provider also count toward the network maximum.

	Coverage Category	Network	Out-of-Network
 	You only	\$5,000	\$10,000
	You + One adult	\$10,000	\$20,000
	You + Child(ren)	\$10,000	\$20,000
	You + Family	\$10,000	\$20,000

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

## lifetime maximum

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

## new coinsurance and copayment amounts for covered medical services

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

- The Medical PPO Plan will continue to include **100 percent** coverage with no copayment, coinsurance or deductible for certain **preventive care services**, as specified by the Affordable Care Act, when you see a network provider. If you see an out-of-network provider you'll pay **40 percent** of maximum allowable amounts and the annual medical deductible will apply.
- If you visit a **network provider**, you'll pay **20 percent** of maximum allowable amounts, and the plan will pay **80 percent**, after you've met your annual deductible for medical services, unless otherwise stated.
- If you visit an **out-of-network provider**, you'll pay **40 percent** of maximum allowable amounts, and the plan will pay **60 percent**, after you've met your annual deductible for medical services, unless otherwise stated.
- There are specific procedures and services for which you're required to notify the claims administrator in accordance with timelines identified in plan rules. Starting in 2017, if you fail to meet the Medical PPO Plan's notification requirements for these procedures and services, then you will pay **40 percent** of maximum allowable amounts, network or out-of-network, after you've met your annual deductible for covered medical services, unless otherwise stated.
- For emergency room visits, you'll pay a **\$250 copayment**, not subject to the deductible, network or out-of-network.
- Anthem defines a **primary care provider** as any of the following: Family Practice, General Practitioner, Pediatrician, Internal Medicine, OB/GYNs, GYNs, Certified Nurse Midwife, Nurse Practitioner, Physician Assistant, and Clinical/Multi Specialty Group. All other professional providers are considered **specialists**.
  - If you see a **network primary care provider**, you'll pay a **\$25 copayment** for the office visit, not subject to the deductible, unless otherwise stated.
  - If see an **out-of-network primary care provider**, you'll pay **40 percent** of maximum allowable amounts for the office visit, after you've met your annual deductible, unless otherwise stated.
  - If you see a **network specialist**, you'll pay a **\$40 copayment** for the office visit, not subject to the deductible, unless otherwise stated.
  - If you see an **out-of-network specialist**, you'll pay **40 percent** of maximum allowable amounts for the office visit, after you've met your annual deductible, unless otherwise stated.



## change to bereavement counseling benefit

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

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



# high deductible health plan

Aside from the switch to a new claims administrator — Anthem Blue Cross — this section provides more detail about other changes to the Chevron High Deductible Health Plan (HDHP) that will be offered to pre-65 eligible retirees and their pre-65 eligible dependents effective January 1, 2017.

## New monthly premium cost

Chevron will currently continue to share the monthly cost of coverage — the premium — with you. The HR Service Center will mail a personalized open enrollment worksheet to you under separate cover in early October. The worksheet includes the 2017 cost for coverage for pre-65 eligible participants. Chevron's company contribution to retiree medical coverage for all non-Medicare medical plans for 2017 will remain the same amount as for 2016.

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

- If you are **currently enrolled in the High Deductible Health Plan (HDHP)**, your enrollment will automatically continue effective January 1, 2017. You do not have to make an enrollment election during open enrollment, unless you want to make a change to your coverage.
- If you want to enroll in the new **High Deductible Health Plan Basic (HDHP Basic)**, you need to make an enrollment election during the upcoming open enrollment period. The HDHP Basic generally covers the same services as the HDHP. The primary difference between the two plan options are your out-of-pocket costs: the premiums, deductibles, copayments and coinsurance. See Page 24 to learn more about the HDHP Basic.

## prescription drug program

If you are enrolled in the HDHP, you automatically have prescription drug coverage through the Prescription Drug Program with Express Scripts. See Page 14 for information about the 2017 Prescription Drug Program.

## health savings account compatible (HSA)

If you enroll in the HDHP, you may also be eligible to open and contribute to a health savings account (HSA), as long as you aren't enrolled in Medicare. Enrollment in the HDHP gives you the keys to open an HSA, but it's your responsibility to determine if you're eligible, choose an HSA provider and then open and contribute to an account. Participation in an HSA is voluntary and is subject to strict enrollment requirements governed by the IRS. For example, you are not eligible to enroll in an HSA if you have coverage under another medical plan, including Medicare, unless it's another high deductible health plan or other permitted coverage. If you are enrolled in Medicare, you cannot open or continue to contribute to an HSA; however you can continue to use existing HSA funds to pay for qualified health care expenses. Consult your tax advisor and read about the requirements in **IRS Publication 969**, available at [www.irs.gov](http://www.irs.gov) to determine if you meet the requirements to open and contribute to an HSA.

The IRS limits how much you can contribute to an HSA for each year. For 2017 the IRS HSA contribution limits are:

- Individual: \$3,400
- Family: \$6,750
- You are allowed to make an extra \$1,000 in catch-up contributions starting in the calendar year in which you turn age 55.



## lifetime maximum

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

## change to bereavement counseling benefit

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


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

## new annual combined deductibles

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

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

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

	Coverage Category	Network	Out-of-Network
	You only	\$2,650	\$5,300
	You + One adult	\$5,300	\$10,600
	You + Child(ren)	\$5,300	\$10,600
	You + Family	\$5,300	\$10,600


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

## new out-of-pocket maximums

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

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

There are different out-of-pocket maximums for medical, prescription drug, mental health and substance abuse services combined, depending on if you see a network provider or an out-of-network provider. These out-of-pocket amounts will change in 2017 for this plan. Note: While covered mental health and substance abuse services will apply to the combined out-of-pocket maximum, know that, depending on your usage, you may actually reach the MHPA Plan's out-of-pocket maximum for covered mental health and substance abuse services *before* you reach the HDHP's combined annual out-of-pocket maximum amount. See Page 30 for more information about the MHPA out-of-pocket maximum amount. Amounts paid for covered services provided by a network provider also count toward the out-of-network maximum. Amounts paid for covered services provided by an out-of-network provider also count toward the network maximum.

	Coverage Category	Network	Out-of-Network
	You only	\$5,000	\$10,000
	You + One adult	\$10,000	\$20,000
	You + Child(ren)	\$10,000	\$20,000
	You + Family	\$10,000	\$20,000

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

## new coinsurance amounts for covered medical services

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

- The HDHP will continue to include **100 percent** coverage with no copayment, coinsurance or deductible for certain **preventive care services**, as specified by the Affordable Care Act, when you see a network provider. If you see an out-of-network provider you'll pay **40 percent** of maximum allowable amounts and the annual combined deductible will apply.
- If you visit a **network provider**, you'll pay **20 percent** of maximum allowable amounts, and the plan will pay **80 percent**, after you've met your annual combined deductible, unless otherwise stated.
- If you visit an **out-of-network provider**, you'll pay **40 percent** of maximum allowable amounts, and the plan will pay **60 percent**, after you've met your annual combined deductible, unless otherwise stated.
- There are specific procedures and services for which you're required to notify the claims administrator in accordance with timelines identified in plan rules. Starting in 2017, if you fail to meet Anthem's notification requirements for these procedures and services, then you will pay **40 percent** of maximum allowable amounts, network or out-of-network, subject to the deductible, unless otherwise stated.
- For emergency room visits, you'll pay **20 percent** of maximum allowable amounts, network or out-of-network, and the plan will pay **80 percent**, after you've met your annual combined deductible, unless otherwise stated.
- Anthem defines a **primary care provider** as any of the following: Family Practice, General Practitioner, Pediatrician, Internal Medicine, OB/GYNs, GYNs, Certified Nurse Midwife, Nurse Practitioner, Physician Assistant, and Clinical/Multi Specialty Group. All other professional providers are considered **specialists**.
  - If you see a **network primary care provider**, you'll pay **20 percent** of maximum allowable amounts for the office visit, after you've met your annual combined deductible, unless otherwise stated.
  - If see an **out-of-network primary care provider**, you'll pay **40 percent** of maximum allowable amounts for the office visit, after you've met your annual combined deductible, unless otherwise stated.
  - If you see a **network specialist**, you'll pay **20 percent** of maximum allowable amounts for the office visit, after you've met your annual combined deductible, unless otherwise stated.
  - If you see an **out-of-network specialist**, you'll pay **40 percent** of maximum allowable amounts for the office visit, after you've met your annual combined deductible, unless otherwise stated.

# high deductible health plan basic

The Chevron HDHP Basic (HDHP Basic) is a new plan choice that will be offered in 2017. With this plan, you pay a low monthly premium in exchange for a high deductible. Participants enrolled in the HDHP Basic may also be eligible to open and contribute to a health savings account (HSA). This section provides more detail about the new HDHP Basic that will be offered to pre-65 eligible retirees and their pre-65 eligible dependents effective January 1, 2017. It's provided to help you make enrollment decisions and understand how this plan works.

## the basics

- You can enroll in the HDHP Basic if you're a pre-65 eligible retiree and you're eligible for Chevron retiree health and welfare benefits.
- You can also enroll your pre-65 eligible dependents, just as you can with Chevron's other health plans.
- The HDHP Basic is a preferred provider organization (PPO) health plan. You can choose to see any provider you want; however, higher benefits are paid when you go to a network provider.
- The HDHP Basic generally covers the same services as the Chevron High Deductible Health Plan (HDHP). The primary difference between the two plan options are your out-of-pocket costs: the premiums, deductibles and coinsurance.
- There are important differences in how a high deductible health plan works that will change how you pay for medical, prescription drug, mental health and substance abuse services under this plan. We'll discuss the differences later in this section.

The HDHP Basic includes:

- **Medical coverage** with Anthem Blue Cross (Anthem).
- **Prescription drug coverage** with Express Scripts.

- **Mental health substance abuse** coverage with Beacon Health Options, as long as you aren't eligible for Medicare.
- In addition, if you enroll in the HDHP Basic, you're also automatically enrolled in the Vision Program for **basic vision coverage** with VSP.

## low monthly premium, high deductible

The HDHP Basic monthly premium cost is the lowest cost plan choice offered by Chevron. If you typically choose your medical plan by monthly premium alone, be sure you understand the trade-off for a low monthly premium before you enroll: a high deductible. While most of the deductibles under all of Chevron's pre-65 retiree medical plans will increase in 2017, the HDHP Basic annual deductible is higher than all the other medical plan options Chevron provides. You have to satisfy the deductible with money out of your own pocket before the HDHP Basic begins to share the cost of covered medical services through coinsurance.

Chevron will currently continue to share the monthly cost of coverage — the premium — with you. The HR Service Center will mail a personalized open enrollment worksheet to you under separate cover in early October. The worksheet includes the 2017 cost for coverage for pre-65 eligible participants. Chevron's company contribution to retiree medical coverage for all non-Medicare medical plans for 2017 will remain the same amount as for 2016.

## how the HDHP basic is similar to other plan choices

The HDHP Basic offers comprehensive coverage for the same major medical services you'd expect, including office visits, emergency services, hospital care, lab services, outpatient care, pregnancy and newborn care and rehabilitative services. It also includes 100 percent coverage with no deductible for certain preventive care services, as specified by the Affordable Care Act, when you see a **network** provider. Additional preventive screenings and services may also be covered, depending on factors like your age and gender. If you see an out-of-network provider, your visit is subject to the deductible and coinsurance will apply.

If you are enrolled in the HDHP Basic, you automatically have prescription drug coverage through the Prescription Drug Program with Express Scripts. For additional summary information about the new HDHP Basic, such as benefits, deductibles, coinsurance and plan contact information, review the plan's Summary of Benefits and Coverage available on [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree).

## health savings account compatible (HSA)

If you enroll in the HDHP Basic, you may also be eligible to open and contribute to a health savings account (HSA). Enrollment in the HDHP Basic gives you the keys to open an HSA, but it's your responsibility to determine if you're eligible, choose an HSA provider and then open and contribute to an account. Participation in an HSA is voluntary and is subject to strict enrollment requirements governed by the IRS. For example, you are not eligible to enroll in an HSA if you have coverage under another medical plan, including Medicare, unless it's another high deductible health plan or other permitted coverage. If you are enrolled in Medicare, you cannot open or continue to contribute to an HSA; however you can continue to use existing HSA funds to pay for qualified health care expenses. Consult your tax advisor and read about the requirements in **IRS Publication 969**, available at [www.irs.gov](http://www.irs.gov) to determine if you meet the requirements to open and contribute to an HSA.


The IRS limits how much you can contribute to an HSA for each year. For 2017 the IRS HSA contribution limits are:

- Individual: \$3,400
- Family: \$6,750
- You are allowed to make an extra \$1,000 in catch-up contributions starting in the calendar year in which you turn age 55.

## annual combined deductible

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

The HDHP Basic has one combined deductible for medical, prescription drugs (both retail and mail-order), mental health and substance abuse services. This means you'll have to pay the full cost for covered services and supplies until you reach the deductible for the year. After you meet the deductible, coinsurance will apply. There are different deductible amounts for covered services depending on if you see a network or an out-of-network provider. Amounts paid for covered services provided by a network provider also count toward the out-of-network annual deductible. Amounts paid for covered services provided by an out-of-network provider also count toward the network annual deductible.


	Coverage Category	Network	Out-of-Network
	You only	\$5,000	\$10,000
	You + One adult	\$10,000	\$20,000
	You + Child(ren)	\$10,000	\$20,000
	You + Family	\$10,000	\$20,000

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

## annual combined out-of-pocket maximum

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

The HDHP Basic has one combined out-of-pocket maximum for medical, prescription drugs (both retail and mail-order), mental health and substance abuse services. The out-of-pocket maximum is the most you will have to pay out-of-pocket for the year for covered services and supplies. When you reach this limit, the HDHP Basic begins to pay 100 percent of the maximum allowable amounts for covered services and supplies. There are different out-of-pocket maximums depending on if you see a network provider or an out-of-network provider. Amounts paid for covered services provided by a network provider also count toward the out-of-network maximum. Amounts paid for covered services provided by an out-of-network provider also count toward the network maximum.

	Coverage Category	Network	Out-of-Network
	You only	\$6,550	\$13,100
	You + One adult	\$13,100	\$26,200
	You + Child(ren)	\$13,100	\$26,200
	You + Family	\$13,100	\$26,200

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

## coinsurance amounts for covered medical services

The HDHP Basic has different coinsurance amounts for covered medical services depending on if you see a network or an out-of-network provider. It's your choice to use any provider you want, but it's important to know that using a network provider will save you money.

- The HDHP Basic will include **100 percent** coverage with no copayment, coinsurance or deductible for certain preventive care services, as specified by the Affordable Care Act, when you see a network provider. If you see an out-of-network provider you'll pay **50 percent** of maximum allowable amounts and the annual combined deductible will apply.
- If you visit a **network provider**, you'll pay **30 percent** of maximum allowable amounts, and the plan will pay **70 percent**, after you've met your annual combined deductible, unless otherwise stated.
- If you visit an **out-of-network provider**, you'll pay **50 percent** of maximum allowable amounts, and the plan will pay **50 percent**, after you've met your annual combined deductible, unless otherwise stated.
- You'll pay **30 percent** of the cost for covered prescription drugs — retail and mail-order — after you've met your annual combined deductible, unless otherwise stated.
- There are specific procedures and services for which you're required to notify the claims administrator in accordance with timelines identified in plan rules. Starting in 2017, if you fail to meet the HDHP Basic's notification requirements for these procedures and services, then you will pay **40 percent** of maximum allowable amounts from a network provider or **50 percent** of maximum allowable amounts from an out-of-network provider, after you've met your annual combined deductible, unless otherwise stated.
- For emergency room visits, you'll pay **30 percent** of maximum allowable amounts, network or out-of-network, after you've met your annual combined deductible, unless otherwise stated.
- Anthem defines a **primary care provider** as any of the following: Family Practice, General Practitioner, Pediatrician, Internal Medicine, OB/GYNs, GYNs, Certified Nurse Midwife, Nurse Practitioner, Physician Assistant, and Clinical/Multi Specialty Group. All other professional providers are considered **specialists**.
  - If you see a **network primary care provider**, you'll pay **30 percent** of maximum allowable amounts for the office visit, after you've met your annual combined deductible, unless otherwise stated.
  - If you see an **out-of-network primary care provider**, you'll pay **50 percent** of maximum allowable amounts for the office visit, after you've met your annual combined deductible, unless otherwise stated.
  - If you see a **network specialist**, you'll pay **30 percent** of maximum allowable amounts for the office visit, after you've met your annual combined deductible, unless otherwise stated.
  - If you see an **out-of-network specialist**, you'll pay **50 percent** of maximum allowable amounts for the office visit, after you've met your annual combined deductible, unless otherwise stated.



# 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 a Medical HMO Plan, you must visit a provider in the HMO's network, otherwise your services 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.

## monthly premium cost

Chevron will currently continue to share the monthly cost of coverage — the premium — with you. The HR Service Center will mail a personalized open enrollment worksheet to you under separate cover in early October. The worksheet includes the 2017 cost for coverage for pre-65 eligible participants. Chevron's company contribution to retiree medical coverage for all non-Medicare medical plans for 2017 will remain the same amount as for 2016.

## deductibles now included under most medical HMO plans

In 2017, most HMOs will introduce a new annual deductible. The average annual deductible for most Medical HMO Plans is **\$300**. However, some Medical HMO Plans may have a different deductible, and a few will continue to have no deductible at all. Go to [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) and click on **2017 Benefit Changes** to review the Summary of Benefits and Coverages for the 2017 deductible amount for each Medical HMO Plan. You'll need to contact the HMO directly starting in January to understand what's included in your deductible.

## other medical HMO plan changes

The Benefits Connection website will list the Medical HMO Plans 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 Medical HMO Plan's Summary of Benefits and Coverage (SBC) for more information about your Medical HMO Plan's features or contact the HMO directly.

- 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's provider network may have changed. Contact your HMO directly to find out if your current provider continues to be in the network. If not, you will need to change providers or choose a new medical plan option to ensure that your medical 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 align them more closely with Chevron's standard benefit design. You'll be able to view more information about Medical HMO Plan changes, if any, in the 2017 Evidence of Coverage document available for each Medical HMO Plan. Contact the HMO directly to request a copy.

## Important reminder about your mental health and substance abuse coverage

Chevron's Medical HMOs continue to include mental health coverage. These services are offered through the HMO, not the Chevron Mental Health and Substance Abuse Plan.



# medical plans for post-65 eligible participants

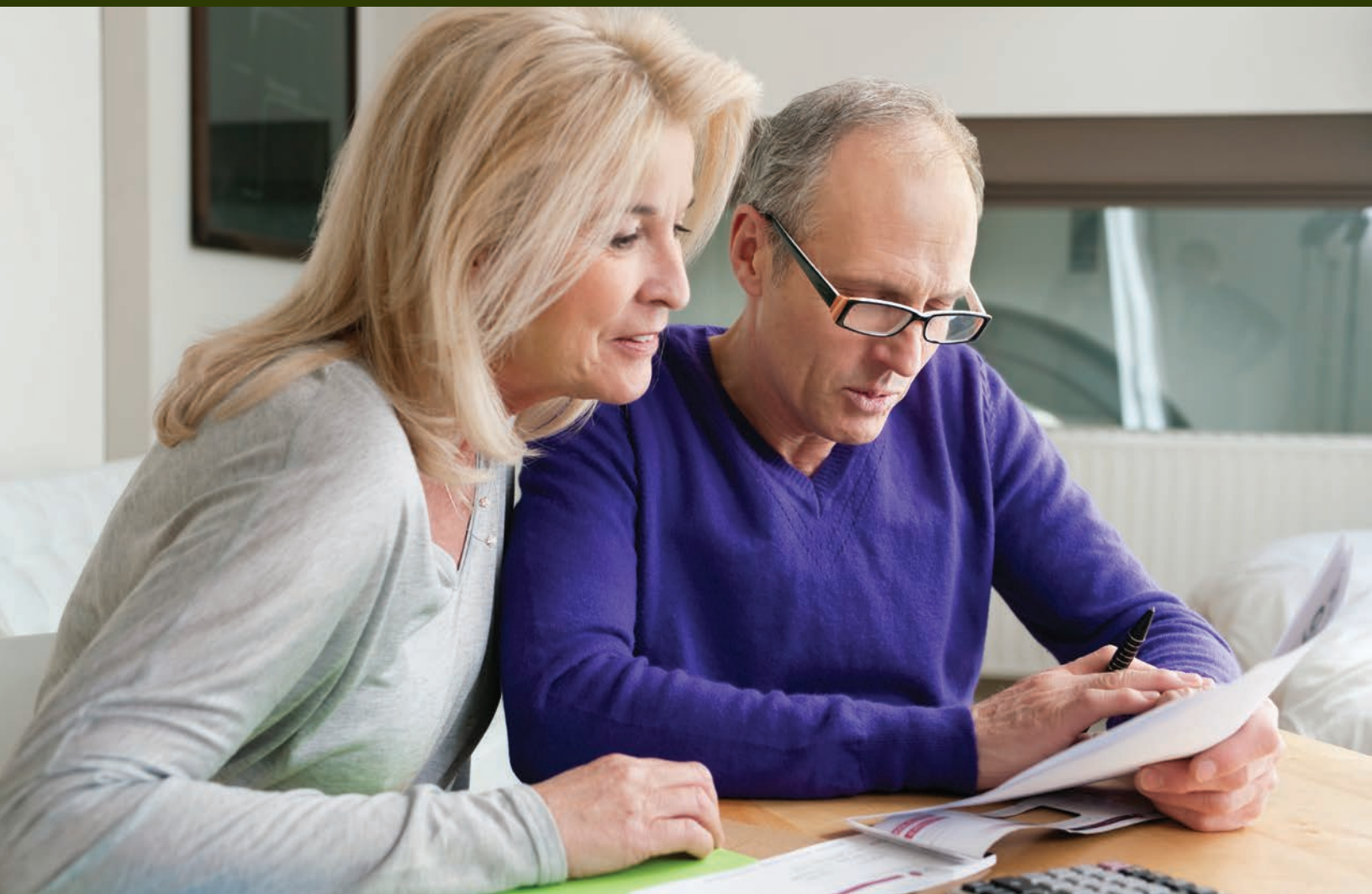
Post-65 eligible retirees and/or their post-65 eligible dependents will only be able to enroll in individual medical, prescription drug, dental and vision coverage through a private health exchange managed by Towers Watson OneExchange. Effective December 31, 2016, Chevron will no longer offer the Chevron Medicare Plus Plan, Chevron Senior Care Plan, Chevron Medicare Standard Plan and Chevron Medicare Medical HMO Plans for post-65 participants.



# mental health and substance abuse plan (MHSA)

for eligible retirees and eligible dependents under age 65

The Mental Health and Substance Abuse (MHSA) Plan, administered by Beacon Health Options, provides confidential support for a wide range of personal issues — from everyday challenges to more serious problems. You and your covered dependents have access to support services 24 hours a day for a variety of concerns such as: depression, stress and anxiety, parenting and family problems or relationship difficulties.



When you and any of your covered dependents enroll in the **Medical PPO Plan**, the **High Deductible Health Plan (HDHP)** or the **High Deductible Health Plan Basic (HDHP Basic)**, mental health coverage is automatically provided by the Chevron Mental Health and Substance Abuse Plan, as long as you aren't eligible for Medicare. If you are enrolled in a **Chevron Medical HMO**, the HMO includes mental health coverage. These services are offered through the HMO, not the Chevron Mental Health and Substance Abuse Plan. When you or any of your enrolled dependents become eligible for Medicare, mental health coverage under the Chevron Mental Health and Substance Abuse Plan will stop for that person because Medicare provides this benefit. However MSHA coverage will continue for other participants as long as they aren't eligible for Medicare and continue to be enrolled in the Medical PPO, HDHP or HDHP Basic.





## 2017 MSHA annual deductible amounts

### Medical PPO Plan

If you are enrolled in the Medical PPO Plan, there is no deductible for mental health and substance abuse services received in network or out-of-network.

### High Deductible Health Plan (HDHP)





If you are enrolled in the Chevron HDHP, there is a combined deductible for medical, prescription drugs, mental health and substance abuse services to satisfy. This means you must satisfy your combined deductible before the MSHA Plan shares the cost of mental health or substance abuse services. So, you'll need to pay out of pocket for covered mental health and substance abuse services until you reach the combined deductible. Effective January 1, 2017, the combined deductible amounts are as follows:

	You only	\$2,650
	You + One adult	\$5,300
	You + Child(ren)	\$5,300
	You + Family	\$5,300

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

### High Deductible Health Plan Basic (HDHP Basic)

The Chevron HDHP Basic is a new medical plan choice effective January 1, 2017. If you are enrolled in the HDHP Basic, there is a combined deductible for medical, prescription drugs, mental health and substance abuse services. This means you must satisfy your combined deductible before the MSHA Plan shares the cost of mental health or substance abuse services. So, you'll need to pay out of pocket for covered mental health and substance abuse services until you reach the combined deductible. Effective January 1, 2017, the combined deductible amounts are as follows:

	You only	\$5,000
	You + One adult	\$10,000
	You + Child(ren)	\$10,000
	You + Family	\$10,000





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



## 2017 MHSA annual out-of-pocket amounts

### Medical PPO Plan





If you are enrolled in the Medical PPO Plan, there is a combined out-of-pocket maximum for medical, mental health and substance abuse services. While covered mental health and substance abuse services will apply to the combined out-of-pocket maximum, be aware that, depending on your usage, you may actually reach the MHSA Plan's out-of-pocket maximum for covered mental health and substance abuse services **before** you reach the Medical PPO Plan's combined annual out-of-pocket maximum amount. Effective January 1, 2017, the out-of-pocket maximum amounts for covered mental health and substance abuse services are as follows:

	You only	\$3,000
	You + One adult	\$6,000
	You + Child(ren)	\$6,000
	You + Family	\$9,000

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

### High Deductible Health Plan (HDHP)





If you are enrolled in the Chevron HDHP, there is a combined out-of-pocket maximum for medical, prescription drugs, mental health and substance abuse services. This combined out-of-pocket HDHP maximum is increasing in 2017. While covered mental health and substance abuse services will apply to the HDHP *combined* out-of-pocket maximum, be aware that, depending on your usage, you may actually reach the MHSA Plan's out-of-pocket maximum for covered mental health and substance abuse services **before** you reach the HDHP combined annual out-of-pocket maximum amount. Effective January 1, 2017, the out-of-pocket maximum amounts for covered mental health and substance abuse services are as follows:

	You only	\$5,000
	You + One adult	\$9,000
	You + Child(ren)	\$9,000
	You + Family	\$10,000

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

### High Deductible Health Plan Basic (HDHP Basic)

If you are enrolled in the Chevron HDHP Basic, there is a combined out-of-pocket maximum for medical, prescription drugs, mental health and substance abuse services. Effective January 1, 2017, the out-of-pocket maximum amounts for covered mental health and substance abuse services are as follows:

	You only	\$6,550
	You + One adult	\$13,100
	You + Child(ren)	\$13,100
	You + Family	\$13,100

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

# dental plan changes

for eligible retirees and eligible dependents under age 65



# dental PPO plan

Chevron has selected **Delta Dental of California** (Delta Dental) to be the claims administrator for the **Chevron Dental PPO Plan** effective January 1, 2017. United Concordia (UCCI) will continue to be the claims administrator for the Dental PPO Plan for the remainder of 2016 (see *Treatment in progress* section for exceptions). This section will describe what you need to know about your Dental PPO Plan because of the change to Delta Dental, including what you'll need to know during the transition and how to access your benefits starting in January.

## do I need to enroll?

If you are **not** currently enrolled in a Chevron dental plan and are eligible for and want to participate in coverage in 2017, you need to make an enrollment election during the upcoming open enrollment period, October 17 through October 28, 2016. If you are currently enrolled in the Chevron Dental PPO Plan, your coverage will automatically continue on January 1, 2017. You do not have to make an enrollment election during open enrollment, unless you want to make a change to your coverage. If you are currently enrolled in a Chevron Dental HMO Plan and you want to change your coverage to the Dental PPO Plan, you'll need to make an election during open enrollment.

## eligibility rules

Who is covered, and who you can cover — the eligibility rules — are the same for the Dental PPO Plan. In addition, if you are pre-65 and enrolled in Chevron pre-65 group dental coverage you may add pre-65 eligible dependents to Chevron pre-65 group dental coverage within 31 days of a qualifying life event — including due to loss of other employer group health coverage — or during Chevron's open enrollment period, as long as the dependent continues to meet eligibility requirements and both you and your dependent are under age 65. The personalized open enrollment worksheet you'll receive from the HR Service Center will list the dental plan options available to you, if any.

## Monthly premium cost

Chevron will currently continue to share the monthly cost of coverage — the premium — with you. The HR Service Center will mail a personalized open enrollment worksheet to you under separate cover in early October. The worksheet includes the 2017 cost for coverage for pre-65 eligible participants.

## new provider network

A network is a group of independent dental care providers that have agreed with your dental plan claims administrator to charge contracted fees for services provided to plan members. With the Dental PPO, you can still see any dentist you choose, but using a network provider saves you money directly by reducing your out-of-pocket costs. With a new claims administrator comes a new provider network. Delta Dental has a different network structure than you're used to with UCCI. Here's how they work.



## Find a provider

Go to [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) and click on **2017 Benefit Changes** to access special links that make it easier to research your provider options.

## Network providers

Delta Dental offers two different types of networks. Both options are considered **network** providers, so they cover the same services, have the same annual maximums, the same coinsurance or copayment levels, and covered services from these providers aren't subject to the deductible. You also don't have to worry about balance billing when you see a provider from either network option. The difference between the two comes down to the reduced fees the dentists have agreed to provide Dental PPO plan participants.

- **Delta Dental PPO<sup>SM</sup> network**

You'll want to find a dentist in the Delta Dental PPO<sup>SM</sup> network to get the greatest savings on your covered dental services. That's because these dentists have agreed to the greatest reduced fees. Why does this matter? Simple math; your coinsurance will apply to a smaller fee so you pay less.

- **Delta Dental Premier<sup>®</sup> network**

If you can't find a Delta Dental PPO<sup>SM</sup> network dentist, a Delta Dental Premier<sup>®</sup> dentist offers the next best opportunity to save. Like the Delta Dental PPO<sup>SM</sup> network dentists, Delta Dental Premier<sup>®</sup> dentists also have agreed to reduced fees, but the savings on these fees aren't as much as with the Delta Dental PPO<sup>SM</sup> network dentists. So your coinsurance amount will be applied to a higher fee, but you're still saving more money than if you visited an out-of-network provider.

## Out-of-network providers

With the Dental PPO, you can still see any dentist you choose, but using a network provider saves you money. When you use an out-of-network dentist, services will be subject to an annual deductible and your coinsurance amounts will be higher, so your out-of-pocket costs will be higher. In addition, out-of-network dentists may balance bill you for the difference between the plan allowance and their usual fee for services.

## treatment in progress

Remember, the Dental PPO Plan is a preferred provider organization plan, so you can continue to use any provider you choose, network or out-of-network. If you began treatment prior to January 1, 2017, work in progress is covered as follows:

- **For active orthodontic treatment**, ask your orthodontist to submit an orthodontic treatment claim to Delta Dental. You should have your orthodontist do this regardless if they are a Delta Dental network provider or not. Delta Dental will then work with your provider regarding the care. The claim form is available on [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) or on the **Delta Dental website**. Any **standard claim form** can also be used. The claim should include:
  - All charges and fees (including the down payment or installments paid by your previous dental plan).
  - Banding date and length of active treatment.
  - Brief description of the dentition, appliance (including type) and treatment.
  - If you are covered by more than one plan, information about the other carrier.

### **For all other treatments, payment of claims for service depends on the service date:**

- If the service date was prior to January 1, 2017, UCCI will continue to pay for claims pertaining to the service, according to the coinsurance or copayment schedules that were in effect during 2016.
- For service dates starting on or after January 1, 2017, Delta Dental will become the claims administrator and the Delta Dental network, deductibles, and coinsurance schedules will apply.

## claims for reimbursement of covered services

If you use an out-of-network provider, typically you'll need to submit a claim to be reimbursed for covered dental services. The Dental PPO Plan generally does not allow benefits to be assigned to an out-of-network provider.

### Submit 2016 claims to United Concordia by June 30, 2017

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

### How to submit claims to Delta Dental

Claim forms are available on the Delta Dental website. Claims forms will also be available on [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree). Use the Delta Dental claim form for covered dental services from an out-of-network dentist on or after January 1, 2017. You can submit claim forms and bills by mail. Keep a copy of your completed claim form and receipts for your records. You can track the status of your claim on the Delta Dental website or the mobile app. And you can always contact Delta Dental if you have questions. (See Page 52 for contact information.)

## new dental PPO plan changes

Due to the change to a new claims administrator for the Dental PPO Plan, the following administrative updates listed below will take effect January 1, 2017:

### The timing of the following covered basic dental care has been changed:

- **Periodontics**

- Treatment of the gums (including scaling and root planing) and supporting tissue.
- Periodontal surgery, not more than two within 36 months of previous treatment.

- **Crowns and inlays**

Adjustments and recementing of crowns and inlays more than 24 months after initial installation. (Initial installation of crowns and inlays is covered under major dental care.) Recementation allowed once per 12 months. Recementation during the first six months following insertion of the crown or bridge by the same dentist is included in the cost of the initial crown or bridge when services are received by a network provider. Crown repairs are also covered under this category.

### The following enhancement has been made to the Covered Basic Dental Care listing:

- Space maintainers, and required adjustments to them, for plan members under age 19.



## annual deductibles, coinsurance, copayments and out-of-pocket maximums

There are no changes to the deductible, coinsurance, copayment and annual maximums for the Dental PPO Plan in 2017. You can view a summary of this information online at [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree).

## new dental ID cards and enrollee ID

Good news. You don't need an ID card so one will not be mailed to you. Just tell your dental office that you're covered by Delta Dental of California and provide your:

- Name
- Date of birth
- Employer Name
- Enrollee ID number (or social security number)

If you have enrolled dependents, tell them to provide your details, not their own.

### Want an ID card anyway?

On January 1, 2017, you have two ways to access your ID card online and make a print out for your use:

- **Print one from your computer.**
  - Go to the Delta Dental website and register as a new user.
  - Login to **Online Services**.
  - Click on **My ID card** and print.
- **Pull it up on your smartphone.**
  - Go to the Delta Dental website and register as a new user.
  - Login to **Online Services**.
  - Select **My ID card** from the main menu.

### What's my Enrollee ID?

Your social security number can also be used to identify you, but we all want to avoid sharing that number whenever possible. Your Enrollee ID is a safer choice. It's available starting January 1, 2017, from the Delta Dental website — and you can see it on your ID card or under your **Eligibility Information** online. You can also call Delta Dental after January 1, 2017 to get the number.

## delta dental website and mobile app

Delta Dental provides three ways for you to stay on top of your dental benefit: visit the website from your computer, access the mobile-optimized website on your smartphone, or download and use the free app. No matter which source you choose you'll be able to:

- Find a dentist (note that you don't have to login to search for a network dentist).
- View your electronic ID card (and grab your Enrollee ID).
- Check deductibles and maximums.
- See your benefits and eligibility.
- Check claims.

### How to register

You can go to the Delta Dental website starting today to search for a network dentist and view general information about your Dental PPO Plan without registering or logging in. However, you need to wait until January 1, 2017, after your enrollment is complete and your Delta Dental coverage starts, to register and access the full site services.

- Go to [www.deltadentalins.com/chevron](http://www.deltadentalins.com/chevron)
- Click on **Register Today** in the **Online Services** section.
- You'll need to provide some basic information to verify your enrollment account.
- You'll need to provide your social security number as you will not yet have your Enrollee ID. This is a one-time request only. You'll get to setup your own username and password as part of the registration process.

### Do I need to find a new dentist?

You can continue to use any provider you choose, network or out-of-network, under the Dental PPO Plan. This means you aren't required to find a new dentist. If your current dentist is not in the Delta Dental PPO<sup>SM</sup> or Delta Dental Premier<sup>®</sup> network, it's still your choice to continue to use that provider or locate a new network provider. Just be sure you understand how that choice affects your out-of-pocket costs. Go to [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) and click on **2017 Benefit Changes** to access special links that make it easier to research your dental provider options.

### Chevron Dental Plan for post-65 participants

Effective December 31, 2016, Chevron will no longer offer the Chevron Dental Plan for post-65 participants. Post-65 eligible retirees and/or their post-65 eligible dependents will only be able to enroll in individual dental coverage through a private health exchange managed by Towers Watson OneExchange.

# dental HMO plans

Chevron offers health maintenance organization (HMO) dental plan options. With an HMO, you must visit a provider in the HMO's network, otherwise your services 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 personalized open enrollment worksheet you'll receive from the HR Service Center will list the dental plan options available to you, if any.

Chevron has selected a new claims administrator for our dental HMO plans. Effective January 1, 2017:

- **Chevron Dental HMO Plan - United Concordia (UCCI).** UCCI is replaced by DeltaCare USA (DeltaCare).
- **Chevron Dental HMO Plan — Cigna Dental.** Cigna is replaced by DeltaCare USA (DeltaCare).

UCCI and Cigna will continue to be the claims administrator for their respective Dental HMO Plan for the remainder of 2016 (see *Orthodontic treatment in progress* section for exceptions). This section will describe what you need to know about your Dental HMO Plan because of the move to Delta, including what you'll need to know during the transition and how to access your benefits starting in January.

## do I need to enroll?

If you are **not currently enrolled in a Chevron dental plan** and are eligible for and want to participate in coverage in 2017, you need to make an enrollment election during the upcoming open enrollment period, October 17 through October 28, 2016. If you are **currently enrolled in either of the Chevron Dental HMO** plans, your coverage will automatically continue on January 1, 2017, as long as it's still available in your zip code. You do not have to make an enrollment election during open enrollment, unless you want to make a change to your coverage. If you are currently enrolled in the Chevron Dental PPO Plan and you want to change your coverage to the Dental HMO Plan — if available in your area — you'll need to make an election during open enrollment.

## eligibility rules

Who is covered, and who you can cover — the eligibility rules — are the same for the Dental HMO Plan. If you are pre-65 and enrolled in Chevron pre-65 group dental coverage you may add pre-65 eligible dependents to Chevron pre-65 group dental coverage within 31 days of a qualifying life event — including due to loss of other employer group health coverage — or during Chevron's open enrollment period, as long as the dependent continues to meet eligibility requirements and both you and your dependent are under age 65.

## Monthly premium cost

Chevron will currently continue to share the monthly cost of coverage — the premium — with you. The HR Service Center will mail a personalized open enrollment worksheet to you under separate cover in early October. The worksheet includes the 2017 cost for coverage for pre-65 eligible participants.

## new provider network

With an HMO you must visit a provider in the HMO's network, otherwise your services aren't covered (except for certain emergency situations). If your provider is not in the network, you will need to change providers or choose a new dental plan option to ensure that your dental services continue to be covered. With a new claims administrator comes a new provider network.

## Primary care dentist

You must visit your selected **DeltaCare USA primary care dentist** to receive benefits under your Dental HMO Plan. Most services not performed by your primary care dentist must be authorized by DeltaCare.

You must select a DeltaCare USA network dentist in order to access benefits under the Dental HMO Plan. If you are enrolled in the Dental HMO Plan, you will be auto assigned to a primary care dentist, when applicable, by DeltaCare. Prior to January 1, you will receive a confirmation in the mail containing your primary care dentist name, your Enrollee ID, an ID card and a description of your benefits from DeltaCare. This package will also provide instructions about how you can change the primary care dentist auto assigned to you. Be sure you take action right away if you want to change to another DeltaCare USA network primary care dentist.

### Do I need to find a new dentist?

With an HMO you must visit a provider in the HMO's network, otherwise your services aren't covered (except for certain emergency situations). If your provider is not in the network, you will need to change providers or choose a new dental plan option to ensure that your dental services continue to be covered. In addition, the Dental HMO Plan requires you to receive services from a DeltaCare USA primary care dentist. A primary care dentist will be automatically assigned to you, but if you want to change dentists, be sure to do so before you schedule an appointment. (See Page 52.)



## Find a provider

Go to [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) and click on **2017 Benefit Changes** to access special links that make it easier to research your provider options.

## new dental ID cards and enrollee ID

You don't need an ID card to receive services, but a DeltaCare USA card for the Dental HMO Plan will be mailed to you prior to January 1. Just tell your dental office that you're covered by DeltaCare USA and provide your:

- Name
- Date of birth
- Employer Name
- Enrollee ID number (or social security number)

If you have enrolled dependents, tell them to provide your details, not their own.

### What's my Enrollee ID?

Your social security number can also be used to identify you, but we all want to avoid sharing that number whenever possible. Your Enrollee ID is a safer choice. DeltaCare will mail a letter to you prior to January 1 that contains your Enrollee ID and ID card, among other useful information.

## orthodontic treatment in progress

The Dental HMO Plan is a health maintenance organization (HMO) dental plan option, so you must visit a provider in the HMO's network, otherwise your services aren't covered. If you or an enrolled dependent has started orthodontic treatment under the UCCI or Cigna Dental plan, you may be able to continue that coverage when you switch to the DeltaCare Dental HMO Plan in 2017. Through a provision called **orthodontic treatment in progress**, your DeltaCare plan allows you to continue treatment you started under your previous dental plan. You can visit the same orthodontist and have the same coverage and copayments as your previous plan. You pay the same amount that you would have paid under your previous coverage, as long as you remain eligible for coverage under your DeltaCare plan.

If you started orthodontic treatment in 2016 (or earlier) under your previous UCCI or Cigna dental plan, and if banding has taken place, you are eligible for continuous orthodontic coverage under your DeltaCare USA Dental HMO Plan and may continue to visit the same orthodontist. If banding has not occurred, you are not eligible for continuous orthodontic coverage. In that case, orthodontic treatment must be provided by a DeltaCare network orthodontist in accordance with the copayments, limitations and exclusions defined in your DeltaCare USA Dental HMO Plan.

**You must sign up between January 1 and January 31, 2017 to receive this continuous orthodontic coverage.** Go to [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) or the DeltaCare website to download the **Continuous Orthodontic Coverage Form** and a **claim form**. Please have your treating orthodontist complete and submit both forms by January 31, 2017. DeltaCare will coordinate benefits as necessary with your orthodontist.

**For all other treatments, payment of claims for service depends on the service date:**

- If the service date was prior to January 1, 2017, your UCCI or Cigna coverage will continue to pay for claims pertaining to the service, according to the UCCI or Cigna copayment and fee schedules.
- For service dates starting on or after January 1, 2017, Delta Dental Insurance Company will become the claims administrator and the DeltaCare USA network, copayment and fee schedules will apply.

## deltacare website and mobile app

DeltaCare provides three ways for you to stay on top of your dental benefit: visit the website from your computer, access the mobile-optimized website via your smartphone, or download and use the free app. No matter which source you choose you'll be able to:

- Find a dentist (note that you don't have to login to search for a network dentist).
- View your electronic ID card (and grab your Enrollee ID).
- See your benefits and eligibility.

### How to register

You can go to the DeltaCare website starting today to search for a provider dentist and view general information about your Dental HMO Plan without registering or logging in. However, you need to wait until January 1, 2017, after your enrollment is complete and your Delta Dental coverage starts, to register and access the full site services.

- Go to [www.deltadentalins.com/chevron](http://www.deltadentalins.com/chevron)
- Click on **Register Today** in the **Online Services** section.
- You'll need to provide some basic information to verify your enrollment account.
- You'll need to provide the **Enrollee ID** mailed to you from DeltaCare USA. You'll get to setup your own username and password as part of the registration process.



# retiree medical program changes

changes to your benefits that take effect January 1, 2017


Effective January 1, 2017, Chevron is changing the way you access and enroll in post-65 retiree medical and prescription drug plan coverage. There are also changes to enrollment rules for all eligible retirees and their eligible dependents. And, the way Chevron shares in the monthly cost of your coverage will also be different. This section replaces and expands upon the enrollment rules first shared in August 2016.

**Important: The information in this section assumes you, the retiree, are eligible for Chevron retiree health and welfare coverage and your dependent(s) also meet the definition of an eligible dependent. The basic rules regarding points and years of service needed to be eligible to participate in retiree medical coverage, the rules for determining eligibility for a company contribution and the company contribution point scale will not change in 2017.**




# retiree health care choices depend on age

Currently, retiree health coverage choices depend primarily on eligibility for Medicare. Beginning in 2017, health coverage choices will also depend on if you (or your eligible dependents) are **pre-65** (under age 65) or are **post-65** (age 65 or over).



**Chevron group coverage**




- medical
- prescription drug
- dental (if eligible)




company contribution in monthly premium

## pre-65 health coverage


Pre-65 eligible retirees and/or their pre-65 eligible dependents will currently continue to be able to participate in generally the same **group health choices** offered to active Chevron employees, with only minor differences.



**OneExchange individual coverage**



- medical
- prescription drug
- dental
- vision



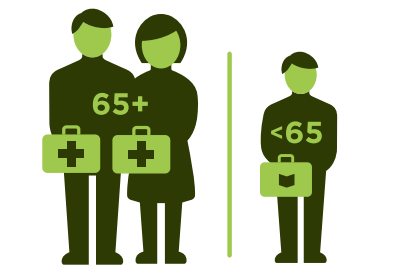
company contribution health reimbursement arrangement (HRA)

## post-65 health coverage

Post-65 eligible retirees and/or their post-65 eligible dependents will only be able to enroll in individual medical, prescription drug, dental and vision coverage through a private health exchange managed by **Towers Watson OneExchange**. Effective December 31, 2016, Chevron will no longer offer the Chevron Medicare Plus Plan, Chevron Senior Care Plan, Chevron Medicare Standard Plan, Chevron Medicare Medical HMOs, or Chevron Dental Plans for post-65 participants.

## what about dependents?

The age of your eligible dependent will dictate if they will enroll in Chevron's pre-65 group health plans or the post-65 OneExchange individual health options. So, if there are both post-65 and pre-65 eligible participants in your family, pre-65 participants will participate in Chevron group health coverage and post-65 participants will participate in individual health coverage through OneExchange.



**Important: You must be enrolled in health coverage offered to Chevron retirees in order to also enroll your eligible dependent.**

# company contributions to medical coverage

As you know, both you and Chevron share the monthly cost of retiree medical coverage, if you're eligible. That philosophy isn't changing at this time. Chevron will currently continue to maintain its contribution to retiree medical coverage. And the rules for determining eligibility for a company contribution and the contribution amount you receive will not change in 2017. However, the way the company contribution is applied to retiree medical coverage may change, depending on age:



**company contribution**  
in monthly premium

---

## pre-65 company contributions

There is no change to the current practice at this time. For pre-65 eligible retirees and/or their pre-65 eligible dependents, the company contribution will continue to be automatically factored into your monthly medical premium for your Chevron pre-65 group medical coverage.



**company contribution**  
health reimbursement  
arrangement (HRA)

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## post-65 company contributions

Effective January 1, 2017, post-65 eligible retirees and/or their post-65 eligible dependents will receive the company contribution in a new way, through a **Health Reimbursement Arrangement**, or HRA. Except for the company contribution for catastrophic prescription drug coverage, your company contribution amount will no longer be automatically applied to your monthly premiums. This is a *reimbursement* account. This means you'll pay premiums for coverage directly to your insurance carriers and submit claims to OneExchange for reimbursement from your HRA. If you and your dependent are eligible for the HRA, you and your post-65 eligible dependent will each have a separate HRA account based on the HRA of the eligible retiree.

## how does the HRA work?

Post-65 eligible retirees and/or their post-65 eligible dependents will receive the monthly company contribution into an HRA. You can use the money in your HRA to help pay the monthly premiums for your Medicare Part B or any of the individual medical, prescription drug, dental or vision plans offered through OneExchange. Your HRA can only be used to pay these specific coverage premiums; it can't be used to pay for other health expenses or pay the premiums for health plans purchased outside of OneExchange. This new contribution approach allows more flexibility in how you spend the company contribution.



## HRA eligibility requirements

You and your eligible dependents are eligible for the HRA if **all** of the following apply to you:

- You qualify as an eligible retiree and you and/or your dependent are post-65 and eligible to participate in the medical coverage offered through OneExchange.
- You and/or your dependent are eligible to receive a company contribution to your retiree medical coverage.

**However, to maintain eligibility for the HRA, all of the requirements listed below must also be met.** If you don't meet these requirements, then you (and any eligible dependents) will not receive the HRA, and you will also lose your eligibility to receive the HRA contribution again in the future. OneExchange will mail information to eligible retirees or dependents in advance of turning age 65 in the future.



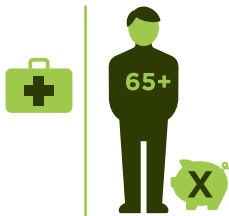
### **You must be enrolled in at least *medical* coverage through OneExchange.**

So, for example, if you only enroll in dental coverage through OneExchange, then you will not receive the HRA and you will also lose your eligibility to receive the HRA contribution again in the future.



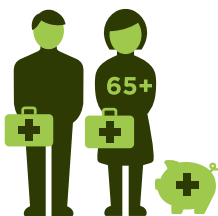
### **You must enroll in medical coverage when first offered the opportunity to enroll through OneExchange (See Page 47 for two exceptions).**

If you don't enroll in medical coverage by the deadline, then you will not receive the HRA and you will also lose your eligibility to receive the HRA contribution again in the future. (See Page 47 for COBRA and loss of group health coverage exceptions.)



### **If you drop medical coverage through OneExchange, you lose eligibility to receive the HRA contribution or use the account.**

You will also lose your eligibility to receive the HRA contribution again in the future.



### **Your post-65 eligible dependent will receive the HRA contribution as long as you and your dependent are enrolled in medical coverage.**

Your post-65 eligible dependent must be enrolled in at least medical coverage through OneExchange. You must also be enrolled in medical coverage, either Chevron group medical coverage if you're pre-65 or OneExchange individual medical coverage if you're post-65. Dependent HRA access and their future HRA eligibility is lost if either you or your dependent don't enroll in medical coverage when first offered, or medical coverage is dropped at any time.

## HRA accounts for chevron couples

You and your post-65 eligible dependents will each have a separate HRA account based on the HRA of the eligible retiree. If you and your spouse are both post-65 Chevron eligible retirees, each separate HRA account will be based on whether you were listed as a dependent or the primary retiree on the day before you enroll with OneExchange.

- If you were listed as a dependent, you will receive the HRA amount of the primary retiree.
- If you were not listed as a dependent (for example, you have Chevron coverage separate from your spouse), you will receive the HRA amount based on the company contribution you are eligible for as a retiree.

## Are you turning age 65 between now and January 1, 2017?

If you (or any of your eligible dependents) are turning age 65 between now and January 1, 2017, your enrollment process will be different. You'll receive health coverage information from both Chevron and OneExchange. **You must enroll with both Chevron and OneExchange to avoid a loss of health coverage.**

- Follow the instructions on Page 7 to enroll in retiree health coverage under Chevron's existing plan options during the Chevron open enrollment period October 17 – October 28, 2016. Keep in mind that the Chevron post-65 retiree coverage you choose ends on December 31, 2016.
- You will also receive enrollment packages from OneExchange. Follow the enrollment instructions you receive from OneExchange to enroll in individual health coverage. This coverage will take effect January 1, 2017, provided you enroll on time.



# enrollment milestones

Beginning in 2017, all benefits-eligible retirees must enroll in Chevron retiree health coverage upon reaching certain milestones; you will not be able to enroll in health coverage during open enrollment or due to a qualifying life event (except as noted below). You must also enroll your eligible dependents at certain milestones. **If you miss these select opportunities to enroll, you and your eligible dependents will not be permitted to return to Chevron retiree health coverage in the future, regardless of open enrollment periods or other qualifying life events.**

**Remember:** If you or an eligible dependent are eligible for the company contribution to an HRA, you and/or your eligible dependent must enroll in at least medical coverage to remain eligible to receive the company contribution.



## when you retire from chevron

**If you or any eligible dependents are pre-65**, contact the HR Service Center within 31 days of your termination date to enroll in retiree health coverage.

**If you or any eligible dependents are post-65, call OneExchange in advance of your termination date** to begin the enrollment process and possibly avoid a gap in coverage when you retire.

**Dependents:** You can add eligible dependents to your coverage at this time.



## at the loss of chevron COBRA coverage

**If you are a pre-65 eligible retiree, you can enroll at the end of Chevron subsidized COBRA or at the end of your Chevron COBRA eligibility period (generally 18 months).** You must call the HR Service Center to enroll within 31 days of loss of Chevron subsidized COBRA or Chevron COBRA. Coverage is generally not automatic. If you miss this deadline, you must wait until the next applicable milestone to enroll in the health coverage offered to Chevron retirees.

**If you are a post-65 eligible retiree, you can enroll when COBRA ends for any reason**, including the end of Chevron subsidized COBRA or at the end of your Chevron COBRA eligibility period. Coverage is not automatic. You must call the HR Service Center within 31 days of the loss of Chevron COBRA to activate your health reimbursement arrangement (HRA). You will then need to call OneExchange to enroll in supplemental medical coverage. To avoid a gap in coverage you must enroll through OneExchange within two months.

**Dependents:** You can add eligible dependents to your coverage at this time, but your dependents must have also been enrolled in Chevron COBRA coverage to be eligible to enroll in the health coverage offered to Chevron retirees.

## Important: One-time enrollment opportunity starts in October

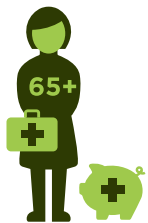
If you're an eligible retiree and are not currently enrolled in Chevron retiree health coverage, or if you need to enroll eligible dependents not currently covered, you have a one-time enrollment opportunity to enroll this fall. (See Page 8 for deadlines.) If you miss the deadline(s), the new enrollment milestones described on Page 47-49 will apply. This means you must wait until the next applicable enrollment milestone to enroll in the health coverage offered to Chevron retirees. If you don't want to add eligible dependents during this one-time enrollment opportunity, be sure to understand the restrictions regarding adding dependents to coverage at a later date. (See Page 49.)



### when you lose chevron or other employer group health coverage

If you — the Chevron eligible retiree — are covered (whether as a primary or as a dependent) under Chevron or another employer's group health coverage and you lose that coverage — regardless of your age — you must call the HR Service Center to enroll within 31 days of the loss of group health coverage. You will be asked to provide proof of loss of employer group health coverage for you and any eligible dependents.

**Dependents:** You can add eligible dependents to coverage at this time, as long as they are also losing the same employer group health coverage.



### when you turn age 65 and become medicare-eligible

When you — the Chevron eligible retiree — turn age 65, you may enroll yourself and eligible dependents in the health coverage offered to Chevron retirees at this time. OneExchange will mail information and enrollment instructions to eligible retirees and eligible dependents in advance of turning age 65 in the future.

**Important: If you don't want to add dependents at each of these enrollment milestones, be sure to understand the restrictions regarding adding dependents to coverage at a later date. See Page 49 for the details.**

## enrolling dependents

Beginning in 2017, retirees must enroll eligible dependents upon reaching certain milestones as described on Page 47-48. If you miss these select opportunities to enroll eligible dependents, you cannot add new dependents, and existing dependents cannot return to your Chevron retiree health coverage in the future (see below for an exception). In addition, post-65 eligible dependents will lose eligibility for the HRA contribution in the future.

- Eligible dependents include your spouse or domestic partner and eligible children. See Page 50 to review dependent definitions.
- The age of your dependent will dictate if they will enroll in Chevron's pre-65 group health plans or the post-65 OneExchange individual health options.
- Your dependent's eligibility to participate in coverage is tied to your — the retiree — participation. If you are not participating or discontinue your health coverage, then your dependent cannot participate in the health coverage offered to Chevron retirees.

### Can I add eligible dependents at a later date?

You can add eligible dependents to the health coverage offered to Chevron retirees according to the rules described for each of the enrollment milestones on Page 47-48. If you don't add eligible dependents when you enroll at these milestones, your ability to add dependents to retiree health coverage at a later date depends on your age and the age of your dependent:

- If you are pre-65 and enrolled in Chevron pre-65 group health coverage (medical only, dental only or both medical and dental), you may add **pre-65 eligible dependents** to Chevron pre-65 group health coverage within 31 days of a qualifying life event — including due to loss of other employer group health coverage — or during Chevron's open enrollment period, as long as the dependent continues to meet eligibility requirements and both you and your dependent are under age 65.

- If you are pre-65 and enrolled in Chevron pre-65 group health coverage (medical only, dental only or both medical and dental), your **post-65 eligible dependents** *cannot* be added to the post-65 coverage through OneExchange. You'll need to wait until the next applicable enrollment milestone (Page 47-48) to enroll your post-65 eligible dependents in the post-65 coverage through OneExchange.
- If you are post-65 and enrolled in post-65 OneExchange coverage, you can continue to cover eligible dependents that are already currently enrolled in health coverage offered to Chevron retirees, but you *cannot* enroll any other existing or new dependents that are not currently enrolled.

### What happens if I drop eligible dependents from coverage?

It's always your choice to drop eligible dependents from health coverage offered to Chevron retirees, but your ability to add your eligible dependents to retiree health coverage again at a later date depends on your age and the age of your dependent:

- If you are pre-65 and enrolled in Chevron pre-65 group health coverage (medical only, dental only or both medical and dental), you may add **pre-65 eligible dependents** back to Chevron pre-65 group health coverage within 31 days of a qualifying life event — including due to loss of other employer group health coverage — or during Chevron's open enrollment period, as long as the dependent continues to meet eligibility requirements and both you and your dependent are under age 65.
- If you are pre-65 and enrolled in Chevron pre-65 group health coverage (medical only, dental only or both medical and dental), if you drop a **post-65 dependent**, the dependent *cannot* be added back to the post-65 coverage through OneExchange. You'll need to wait until the next applicable enrollment milestone (Page 47-48) to enroll your post-65 eligible dependents in the post-65 coverage through OneExchange.
- If you are post-65 and you drop dependents from coverage, your dependents *cannot* be added back to the health coverage offered to Chevron retirees, regardless of age.

# dependent definitions

The following are definitions of an eligible dependent for purposes of eligibility to participate in the health coverage offered to Chevron retirees.

## 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. 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.

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

In general, if you die, your enrolled dependents are eligible for either continuation coverage or survivor coverage. For more information, see the *Continuation Coverage and COBRA Coverage* section in the **Your Chevron Benefits in Retirement** summary plan description available on [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) or by calling the HR Service Center and requesting that a copy be mailed to you. If you retired before July 1, 2002, there may be special eligibility and cost rules for your enrolled surviving spouse, which may depend on the heritage company from which you retired. For example, per former Texaco's practice, survivors of Texaco retirees who retired before July 1, 2002, are eligible for the medical plans (not dental), but must pay the total cost of the medical plan after the retiree dies. When the Texaco survivor becomes Medicare-eligible, then the company pays 50 percent of the maximum company contribution.

## eligible domestic partner

You can enroll your domestic partner for health plan coverage if you retired from Chevron after January 1, 1998, or if you are a former Texaco employee, you retired from Chevron on or after July 1, 2002. (However, former Gulf, former Texaco, former Getty, former Caltex, and former Amoseas employees who retired before July 1, 2002, and former Unocal employees who retired before July 1, 2006, are not eligible to cover a domestic partner.)

To qualify for benefits available to domestic partners of Chevron retirees, 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 must be notarized and sent to the HR Service Center. By signing the affidavit, you certify that you and your partner meet the qualifications listed on the affidavit.

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.



If you die, your enrolled dependents are eligible for either continuation coverage or survivor coverage. For more information, see the *Continuation Coverage and COBRA Coverage* section in the **Your Chevron Benefits in Retirement** summary plan description available on [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) or by calling the HR Service Center and requesting that a copy be mailed to you. If you retired before July 1, 2002, there may be special eligibility and cost rules for your enrolled surviving spouse, which may depend on the heritage company from which you retired.

## eligible children and other dependents

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

- You or your spouse's/domestic partner's natural child, step child, 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.

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.

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* section of the **Your Chevron Benefits in Retirement** summary plan description. 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* of the **Your Chevron Benefits in Retirement** summary plan description available on [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) or by calling the HR Service Center and requesting that a copy be mailed to you.

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

In general, if you die, your enrolled dependents are eligible for either continuation coverage or survivor coverage. For more information, see the *Continuation Coverage and COBRA Coverage* section in the **Your Chevron Benefits in Retirement** summary plan description available on [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) or by calling the HR Service Center and requesting that a copy be mailed to you. If you retired before July 1, 2002, there may be special eligibility and cost rules for your enrolled surviving spouse, which may depend on the heritage company from which you retired.



# contact your plan

This section includes contact information for your benefit plans and programs.  
If you don't see information for a plan you're looking for, go to [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree).



## Chevron HR Service Center

<b>Phone Numbers</b>	<p>Please note the HR Service Center can answer questions about 2017 benefits starting <b>October 17, 2016.</b></p> <ul style="list-style-type: none"><li>• 1-888-825-5247 when calling from inside the U.S.</li><li>• 610-669-8595 when calling from outside the U.S.</li><li>• 6 a.m. to 5 p.m. Pacific time (8 a.m. to 7 p.m. Central time)</li><li>• Monday through Friday (except on holidays).</li></ul>
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## Dental PPO Plan

<b>Claims Administrator</b>	Delta Dental of California
<b>Network Name</b>	<ul style="list-style-type: none"><li>• Delta Dental PPO<sup>SM</sup></li><li>• Delta Dental Premier<sup>®</sup></li></ul>
<b>Group Number</b>	<ul style="list-style-type: none"><li>• 18368</li></ul>
<b>Direct Phone Numbers</b>	<ul style="list-style-type: none"><li>• 1-800-228-0513 (Inside the U.S.)</li><li>• 415-972-8300 (Outside the U.S.)</li><li>• 5 a.m. — 5 p.m. Pacific (7 a.m. — 7 p.m. Central)</li></ul>
<b>Website</b>	<ul style="list-style-type: none"><li>• <a href="http://www.deltadentalins.com/chevron">www.deltadentalins.com/chevron</a></li><li>• Full site available on January 1, 2017. Provider search available today.</li></ul>
<b>Mobile App</b>	<ul style="list-style-type: none"><li>• Delta Dental app</li></ul>

## High Deductible Health Plan (HDHP)

<b>Claims Administrator</b>	<ul style="list-style-type: none"> <li>• <b>Medical coverage:</b> Anthem Blue Cross</li> <li>• <b>Prescription drug coverage:</b> Express Scripts</li> <li>• <b>Basic vision coverage:</b> VSP</li> </ul>
<b>Network Name</b>	<ul style="list-style-type: none"> <li>• <b>Medical coverage:</b> National PPO</li> <li>• <b>Prescription drug coverage:</b> National Plus Network</li> <li>• <b>Basic vision coverage:</b> VSP Choice</li> </ul>
<b>Group Number</b>	<ul style="list-style-type: none"> <li>• <b>Medical coverage:</b> 174209</li> <li>• <b>Prescription drug coverage:</b> CT1839</li> <li>• <b>Basic vision coverage:</b> 30021085</li> </ul>
<b>Direct Phone Numbers</b>	<p><b>Medical coverage</b> Anthem Blue Cross</p> <ul style="list-style-type: none"> <li>• 1-844-627-1632</li> </ul> <p><b>Prescription drug coverage</b> Express Scripts</p> <ul style="list-style-type: none"> <li>• 1-800-987-8368</li> </ul> <p><b>Basic vision coverage</b> VSP</p> <ul style="list-style-type: none"> <li>• 1-800-877-7195 (Inside the U.S.)</li> <li>• 1-916-851-5000 (Outside the U.S.) - press '0' for operator assistance</li> </ul>
<b>Website</b>	<ul style="list-style-type: none"> <li>• <b>Medical coverage:</b> <a href="http://www.anthem.com/ca">www.anthem.com/ca</a></li> <li>• <b>Prescription drug coverage:</b> <a href="http://www.express-scripts.com">www.express-scripts.com</a></li> <li>• <b>Basic vision coverage:</b> <a href="http://www.vsp.com/go/chevron">www.vsp.com/go/chevron</a></li> </ul>
<b>Mobile App</b>	<ul style="list-style-type: none"> <li>• <b>Medical coverage:</b> Anthem Anywhere app</li> <li>• <b>Prescription drug coverage:</b> Express Scripts app</li> </ul>

## High Deductible Health Plan Basic (HDHP Basic)

<b>Claims Administrator</b>	<ul style="list-style-type: none"> <li>• <b>Medical coverage:</b> Anthem Blue Cross</li> <li>• <b>Prescription drug coverage:</b> Express Scripts</li> <li>• <b>Basic vision coverage:</b> VSP</li> </ul>
<b>Network Name</b>	<ul style="list-style-type: none"> <li>• <b>Medical coverage:</b> National PPO</li> <li>• <b>Prescription drug coverage:</b> National Plus Network</li> <li>• <b>Basic vision coverage:</b> VSP Choice</li> </ul>
<b>Group Number</b>	<ul style="list-style-type: none"> <li>• <b>Medical coverage:</b> 174209</li> <li>• <b>Prescription drug coverage:</b> CT1839</li> <li>• <b>Basic vision coverage:</b> 30021085</li> </ul>
<b>Direct Phone Numbers</b>	<p><b>Medical coverage</b> Anthem Blue Cross</p> <ul style="list-style-type: none"> <li>• 1-844-627-1632</li> </ul> <p><b>Prescription drug coverage</b> Express Scripts</p> <ul style="list-style-type: none"> <li>• 1-800-987-8368</li> </ul> <p><b>Basic vision coverage</b> VSP</p> <ul style="list-style-type: none"> <li>• 1-800-877-7195 (Inside the U.S.)</li> <li>• 1-916-851-5000 (Outside the U.S.) - press '0' for operator assistance</li> </ul>
<b>Website</b>	<ul style="list-style-type: none"> <li>• <b>Medical coverage:</b> <a href="http://www.anthem.com/ca">www.anthem.com/ca</a></li> <li>• <b>Prescription drug coverage:</b> <a href="http://www.express-scripts.com">www.express-scripts.com</a></li> <li>• <b>Basic vision coverage:</b> <a href="http://www.vsp.com/go/chevron">www.vsp.com/go/chevron</a></li> </ul>
<b>Mobile App</b>	<ul style="list-style-type: none"> <li>• <b>Medical coverage:</b> Anthem Anywhere app</li> <li>• <b>Prescription drug coverage:</b> Express Scripts app</li> </ul>

## Medical PPO Plan

<b>Claims Administrator</b>	<ul style="list-style-type: none"> <li>• <b>Medical coverage:</b> Anthem Blue Cross</li> <li>• <b>Prescription drug coverage:</b> Express Scripts</li> <li>• <b>Basic vision coverage:</b> VSP</li> </ul>
<b>Network Name</b>	<ul style="list-style-type: none"> <li>• <b>Medical coverage:</b> National PPO</li> <li>• <b>Prescription drug coverage:</b> National Plus Network</li> <li>• <b>Basic vision coverage:</b> VSP Choice</li> </ul>
<b>Group Number</b>	<ul style="list-style-type: none"> <li>• <b>Medical coverage:</b> 174209</li> <li>• <b>Prescription drug coverage:</b> CT1839</li> <li>• <b>Basic vision coverage:</b> 30021085</li> </ul>
<b>Direct Phone Numbers</b>	<p><b>Medical coverage</b> Anthem Blue Cross</p> <ul style="list-style-type: none"> <li>• 1-844-627-1632</li> </ul> <p><b>Prescription drug coverage</b> Express Scripts</p> <ul style="list-style-type: none"> <li>• 1-800-987-8368</li> </ul> <p><b>Basic vision coverage</b> VSP</p> <ul style="list-style-type: none"> <li>• 1-800-877-7195 (Inside the U.S.)</li> <li>• 1-916-851-5000 (Outside the U.S.) - press '0' for operator assistance</li> </ul>
<b>Website</b>	<ul style="list-style-type: none"> <li>• <b>Medical coverage:</b> <a href="http://www.anthem.com/ca">www.anthem.com/ca</a></li> <li>• <b>Medical provider search:</b> <a href="http://hr2.chevron.com/retiree">hr2.chevron.com/retiree</a> Click 2017 Benefit Changes</li> <li>• <b>Prescription drug coverage:</b> <a href="http://www.express-scripts.com">www.express-scripts.com</a></li> <li>• <b>Basic vision coverage:</b> <a href="http://www.vsp.com/go/chevron">www.vsp.com/go/chevron</a></li> </ul>
<b>Mobile App</b>	<ul style="list-style-type: none"> <li>• <b>Medical coverage:</b> Anthem Anywhere app</li> <li>• <b>Prescription drug coverage:</b> Express Scripts app</li> </ul>

## Mental Health and Substance Abuse Plan

<b>Claims Administrator</b>	Beacon Health Options
<b>Direct Phone Numbers</b>	<b>Beacon Health Options</b> <ul style="list-style-type: none"><li>• 1-800-847-2438 (Inside the U.S.)</li><li>• 714-763-2420 (Outside the U.S. call collect)</li></ul> <b>Chevron's Employee Assistance and Worklife Services</b> <ul style="list-style-type: none"><li>• 1-800-860-8205</li><li>• CTN 842-3333</li></ul>
<b>Website</b>	• <a href="http://www.valueoptions.com">www.valueoptions.com</a>

## OneExchange

<b>Direct Phone Numbers</b>	Health benefits for post-65 eligible retirees and their post-65 eligible dependents. <ul style="list-style-type: none"><li>• 1-844-266-1392 (Inside the U.S.)</li><li>• 1-801-994-9805 (Outside the U.S.)</li><li>• 5 a.m. — 6 p.m. Pacific time (7 a.m. — 8 p.m. Central time)</li></ul>
<b>Website</b>	• <a href="https://medicare.oneexchange.com/chevron">https://medicare.oneexchange.com/chevron</a>

# what to expect next

## more communications coming in the mail

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### Early October

#### **Open enrollment worksheet from Chevron HR Service Center**

*Sent to pre-65 eligible and/or pre-65 eligible dependents that are eligible for Chevron pre-65 retiree group health benefits.* Personalized information about pre-65 Chevron group coverage choices and costs.

#### **Enrollment Guide package from OneExchange**

*Sent to post-65 eligible and/or post-65 eligible dependents that are eligible for individual Chevron retiree health benefits through OneExchange.* Additional OneExchange post-65 enrollment information that's required, by law, to be issued to you. It also includes a quick reference guide — HRA Payment and Reimbursement Overview — with more information about how you'll pay for post-65 coverage in 2017 and what you need to do to be reimbursed from your Health Reimbursement Arrangement (HRA) for those premiums, if applicable.

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## post-65 informational meeting

OneExchange is currently conducting information sessions to talk about these changes. The last live meeting is in early October. If you cannot attend a live meeting you can now also review a recording. Invite your eligible dependents, family members, or caregivers to listen or watch with you.

- **A recording on the phone.**  
Call 1-844-431-7914.
- **Online webcast video.** Go to <https://medicare.oneexchange.com/chevron>.

## your online resource

The U.S. Benefits website is your one-stop source for information about these changes, including links to Benefits Connection, OneExchange and claims administrators. It will be updated with additional details throughout the fall. You can access this website from home or on any mobile device with internet access.

- [hr2.chevron.com/retiree](https://hr2.chevron.com/retiree)  
Click on **2017 Benefit Changes** banner.

## pre-65 informational meeting

Chevron will conduct online information webinars to talk about the 2017 benefit changes for pre-65 retirees and their pre-65 dependents. The meetings begin in early October. If you cannot attend one of the live webinars, a recording is also available online to watch any time, at your convenience. For the webinar schedule or to review the recording, go to:

- [hr2.chevron.com/retiree](https://hr2.chevron.com/retiree)  
Click on **2017 Benefit Changes** banner.



# legally required notices

no action required by you

## Women's Health and Cancer Rights Notice

To comply with the Women's Health and Cancer Rights Act of 1998, Chevron reminds you that all medical plans the company offers cover medically necessary mastectomy and related breast reconstructive surgery, including reconstruction of the breast on which the mastectomy is performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment remedies for physical complications during all stages of the mastectomy, including lymphedema.

## Free or Low-Cost Health Coverage to Children and Families

To comply with the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Chevron reminds you that if you are eligible for health coverage from Chevron or another employer, but are unable to afford the monthly premiums, you may qualify for a premium assistance program that some states offer to help pay for your coverage. These states use funds from their Medicaid or Children's Health Insurance Program (CHIP) programs to help people who are eligible for employer-sponsored health coverage but need assistance with paying their health premiums. For a list of states that participate in premium assistance, go to [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree).

- 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 dependents might be eligible for either program, contact your state's Medicaid or CHIP office. You can also call **1-877-Kids-Now** or visit [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to learn how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

## Special enrollment opportunity

If it's determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, 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 HR Service Center and request Chevron health coverage within 60 days of being determined eligible for Medicaid or CHIP premium assistance. If you enroll within the 60-day time limit, Medicaid or CHIP will subsidize, or pay for, a portion of the Chevron health plan premium cost.

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

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at **1-888-825-5247** (610-669-8595 outside the U.S.). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **1-866-444-3272** or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.



# Update to the Summary Plan Description

## Effective January 1, 2017

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

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

You can access the summary plan descriptions for your benefits on the Internet at [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) 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, 2017 High Deductible Health Plan Basic (HDHP Basic) Summary Plan Description**

## **Important Correction**

### **U.S. Retiree Benefits Newsletter, “Open Enrollment is Here” September 2016**

The High Deductible Health Plan Basic section of the newsletter/summary material modification incorrectly listed temporomandibular joint (TMJ) disorder as having a lifetime maximum under the plan. The correct statement about lifetime maximums under the plan is listed below.

#### **Lifetime Maximum**

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

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# Update to the Summary Plan Description

## Effective January 1, 2016

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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/retiree](http://hr2.chevron.com/retiree) 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 Your Chevron Benefits in Retirement 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.)

## Dental Plans

There are no plan changes to the **Dental HMO** or **Dental PPO Plans** in 2016. A Dental HMO option may be available to you in your area. The personal enrollment worksheet included in this open enrollment package will list any Dental HMOs available to you next year.

Be sure to review the enclosed personal enrollment worksheet to review your actual 2016 cost information, including the amount Chevron will contribute to your coverage. Your cost for coverage under the **Dental PPO Plan** will *increase* by approximately **2%** for 2016. Depending on the plan, the monthly premiums for some **Dental HMO** plans will *decrease* by approximately **5%**, while other Dental HMO plans will *increase* by up to **7%**.

## Vision

Retirees enrolled the **Medical PPO Plan**, the **High Deductible Health Plan**, the **Medicare Plus Plan**, the **Medicare Standard Plan** and the **Senior Care Plan** are automatically enrolled in the Vision Program for basic vision coverage. There are no plan changes to the Vision Program in 2016. VSP is the insurer for your vision coverage. The VSP provider network is made up of primarily private practice vision providers across the United States. All VSP private practice doctors provide exams and have materials, such as glasses and contacts, available in their offices. The plan provides 100 percent coverage for an annual comprehensive eye exam, including dilation as needed, from a network provider. If you have questions about your vision coverage, contact VSP at **1-800-877-7195**, or go to [www.vsp.com/go/chevron](http://www.vsp.com/go/chevron).

If you're enrolled in a **Medical HMO** or **Medicare Medical HMO Plan**, vision services (if any) are provided through your Medical HMO Plan.

# Medical PPO Plan (Option 1, Option 2)

## 2016 Monthly Cost Overview

Be sure to review the enclosed personal **enrollment worksheet** with your actual 2016 cost information, including the amount Chevron will contribute to your coverage. Chevron's company contribution for retiree coverage to all non-Medicare medical plans for 2016 will remain the same amount as for 2015.

As you know, Chevron currently shares the monthly cost of coverage - the premium - for your medical and dental plans. Our total premium cost is determined, in part, by the actual health care expenses incurred by the plans in the previous year. As a result of higher than expected health claims experience, the monthly premiums for the **Medical PPO Plan** will *increase* by an average of **24% for Option 1** and **26% for Option 2** in 2016, depending on when you retired.

## Changes to Medical Coverage

- Currently, the Medical PPO Plan requires that another method of pain management has been tried and failed before **acupuncture coverage** begins. This requirement will be removed effective January 1, 2016.
- Effective January 1, 2016, **virtual visits** are available for covered health services that include the diagnosis and treatment of low acuity medical conditions for covered persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to [www.myuhc.com](http://www.myuhc.com) or by calling 1-800-654-0079.

Note that not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person physician contact is necessary. In addition, benefits under this provision do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities.



## Changes to Prescription Drug Coverage

If you are enrolled in the **Medical PPO Plan**, you automatically have prescription drug coverage through the Prescription Drug Program with Express Scripts. The prescription drug changes described in this section take effect on January 1, 2016. For additional details, contact Express Scripts Member Services at **1-800-987-8368**, or review the documents and links available from [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree). Choose the **Open Enrollment** link to get started.

### Deductible Increase

There is a separate deductible for prescription drugs under the **Medical PPO Plan**.

#### Option 1 and Option 2 Deductible\*



#### Prescription Drugs

You Only	<b>\$360 ↑</b>
You + Family	<b>\$720 ↑</b>

\* For Option 1 and Option 2, each covered individual has a maximum deductible equal to the You Only deductible amount. No more than the You Only deductible amount can be applied toward the family deductible for any one person to satisfy the You + Family deductible.

## New Prior Authorizations

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

- Anticoagulants (Pradaxa, Xarelto, Eliquis)
- Suboxone

## New Medications Subject to Preferred Step Therapy

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

- **Topical Acne**  
(For example: Cleocin T, Ancanya, Ziana, Veltin, Benzac AC, Azelex)
- **Topical Corticosteroids**  
(For example: Synalar, Cordran, Halog, Topicort, Diprolene)

## Some Compound Medications Not Covered

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

**A number of these commonly used primary ingredients for compounds have been identified and will no longer be covered by the Chevron Prescription Drug Program.** These include, but are not limited to, powder forms of various pain and anti-inflammatory agents. **Beginning January 1, 2016, if you are using a compound medication in which the primary ingredient is one of these agents, and it's in a dosage form such as a bulk powder, the medication will no longer be covered.**

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

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

If you are currently taking or are prescribed a compound medication, you can call **Express Scripts Member Services at 1-800-987-8368** to verify if your medication is covered or excluded. After January 1, 2016, you can also go to the Express Scripts website at [www.express-scripts.com](http://www.express-scripts.com) and search for your medication to verify the coverage status.

## PCSK9 Inhibitor Drug Class

### New Prior Authorization Program

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

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

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

- **A clinical review process by a dedicated clinical team.** With every new request for PCSK9 inhibitors, a dedicated Express Scripts clinical team, with pharmacists who specialize in cardiovascular disease, will employ a robust clinical review, which includes collecting clinical documentation and holding discussions with your physician, before approving your use of a PCSK9 inhibitor.
- **Enhanced care for patients starting PCSK9s.** If you're changing therapy, you will automatically receive assistance and education from the Cholesterol Care team at Accredo, the Express Scripts specialty pharmacy. Accredo, will initially dispense three, 30-day prescriptions to ensure therapy tolerance before moving to a 90-day fill.

If you have questions, contact Express Scripts Member Services at **1-800-987-8368**.

# High Deductible Health Plan (HDHP)

The **Chevron HDHP** is available to retirees and their dependents who are *not* enrolled in Medicare. The HDHP is a preferred provider organization (PPO) health plan that includes medical coverage with UnitedHealthcare, prescription drug coverage with Express Scripts, and Mental Health Substance Abuse coverage with Value Options. In addition, if you enroll in the HDHP, you're also automatically enrolled in the Vision Program for basic vision coverage with VSP. You can choose to see any provider you want; however, higher benefits are paid when go to a network provider. With this plan you pay a low monthly premium in exchange for a high deductible. Participants enrolled in the HDHP may also be eligible to open and contribute to a health savings account (HSA).

## 2016 Monthly Cost Overview

Be sure to review the enclosed personal **enrollment worksheet** with your actual 2016 cost information, including the amount Chevron will contribute to your coverage. Chevron's company contribution for retiree coverage to all non-Medicare medical plans for 2016 will remain the same amount as for 2015.

Chevron currently shares the monthly cost of coverage - the premium - for your medical and dental plans. Our total premium cost is determined, in part, by the actual health care expenses incurred by the plans in the previous year. As a result of higher than expected health claims experience, the monthly premiums for the **High Deductible Health Plan** will *increase* by an average of **32%** for 2016.

## Health Savings Account (HSA) Reminders

If you enroll in the HDHP, you may be eligible to enroll in and contribute to a **health savings account (HSA)**, as long as you aren't enrolled in Medicare. An HSA is like a savings plan for health care. You can use an HSA to pay for qualified health care expenses this year, three years from now or at any point in the future. If you decide to change medical plans and leave the HDHP in 2016, and you have an established health savings account, you can continue to use the funds in your HSA to pay for qualified health care expenses.

Participation in an HSA is voluntary and is subject to strict enrollment requirements governed by the IRS. For example, you are not eligible to enroll in an HSA if you have coverage under another medical plan, including Medicare, *unless* it's another high deductible health plan or other permitted coverage. If you are enrolled in Medicare, you cannot open or continue to contribute to an HSA; however you can continue to use existing HSA funds to pay for qualified health care expenses. You are responsible for understanding how an HSA works and making contributions.

You can choose from HSAs offered by any financial institution that offers them, including the Chevron Federal Credit Union, but it's up to you to find the one that meets your needs. Chevron does not provide an HSA to retirees, and Chevron cannot offer counsel about HSAs. Be sure to consult with your financial advisor about your personal situation.

You can read about HSA eligibility requirements at [www.irs.gov](http://www.irs.gov), *Publication 969* or learn about HSA qualified expenses in *Publication 502*.

## IRS Limits Your Contributions to an HSA

The IRS limits how much you can contribute your HSA between January 1 and December 31 of each year. Your contribution limits are determined by the level of coverage (such as *You Only* or *You + One Adult*) you've selected in a qualifying, high deductible health plan such as the Chevron HDHP. Monitor your contributions carefully. It is your responsibility to track the total contributions you make during the year; Chevron cannot track your contributions against the annual limit. If you contribute over the limit, you may be subject to taxes and penalties. For 2016 the limits are:\*

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

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



## Changes to Medical Coverage

- Currently, the HDHP requires that another method of pain management has been tried and failed before **acupuncture coverage** begins. This requirement will be removed effective January 1, 2016.
- Effective January 1, 2016, **virtual visits** are available for covered health services that include the diagnosis and treatment of low acuity medical conditions for covered persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to [www.myuhc.com](http://www.myuhc.com) or by calling 1-800-654-0079.

Note that not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person physician contact is necessary. In addition, benefits under this provision do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities.



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### New Prior Authorizations

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- Anticoagulants (Pradaxa, Xarelto, Eliquis)
- Suboxone

### New Medications Subject to Preferred Step Therapy

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

- **Topical Acne**  
(For example: Cleocin T, Ancanya, Ziana, Veltin, Benzac AC, Azelex)
- **Topical Corticosteroids**  
(For example: Synalar, Cordran, Halog, Topicort, Diprolene)

## Some Compound Medications Not Covered

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

**A number of these commonly used primary ingredients for compounds have been identified and will no longer be covered by the Chevron Prescription Drug Program.** These include, but are not limited to, powder forms of various pain and anti-inflammatory agents. **Beginning January 1, 2016, if you are using a compound medication in which the primary ingredient is one of these agents, and it's in a dosage form such as a bulk powder, the medication will no longer be covered.**

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

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

If you are currently taking or are prescribed a compound medication, you can call **Express Scripts Member Services at 1-800-987-8368** to verify if your medication is covered or excluded. After January 1, 2016, you can also go to the Express Scripts website at [www.express-scripts.com](http://www.express-scripts.com) and search for your medication to verify the coverage status.

## PCSK9 Inhibitor Drug Class

### New Prior Authorization Program

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

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

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

- **A clinical review process by a dedicated clinical team.** With every new request for PCSK9 inhibitors, a dedicated Express Scripts clinical team, with pharmacists who specialize in cardiovascular disease, will employ a robust clinical review, which includes collecting clinical documentation and holding discussions with your physician, before approving your use of a PCSK9 inhibitor.
- **Enhanced care for patients starting PCSK9s.** If you're changing therapy, you will automatically receive assistance and education from the Cholesterol Care team at Accredo, the Express Scripts specialty pharmacy. Accredo, will initially dispense three, 30-day prescriptions to ensure therapy tolerance before moving to a 90-day fill.

If you have questions, contact Express Scripts Member Services at **1-800-987-8368**.

# Medical HMO Plans

## Not Eligible for Medicare

A Medical HMO option may be available to you in your area. The personal enrollment worksheet included in this open enrollment package will list any HMOs available to you next year.

### 2016 Monthly Cost Overview

Be sure to review the enclosed personal **enrollment worksheet** with your actual 2016 cost information, including the amount Chevron will contribute to your coverage, for the HMO plans that apply to you (if any). Chevron's company contribution for retiree coverage to all non-Medicare medical plans for 2016 will remain the same amount as for 2015.

HMOs are products that Chevron purchases on behalf of our employees and retirees, and premiums are set by the HMOs based on their specific claims experience. Depending on the plan, the monthly premiums for some **Medical HMO plans** will *decrease* by approximately up to **8%**, while other plans will *increase* by approximately up to **34%**.

### Medical HMO Reminders

- Even if your current Medical 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 Medical HMO provider may have changed. Remember that HMOs require you to use doctors and hospitals that are part of their provider network. Contact your medical HMO directly to find out if your current providers continue to be in the network. If they aren't, you will need to change providers or choose a new plan to ensure that your medical services continue to be covered.
- Copayment and other changes in your current Medical 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.
- Chevron's Medical HMOs continue to include mental health coverage. These services are offered through the HMO, *not* the Chevron Mental Health and Substance Abuse Plan.

## Medical HMO - Altius UT Will Not Be Offered in 2016

This plan will no longer be available to retirees or active employees effective January 1, 2016. Retirees and their eligible dependents that are currently enrolled in this plan will be automatically enrolled in another Chevron medical plan for 2016. Participants not eligible for Medicare will be automatically enrolled in the **Medical PPO Plan - Option 1** effective January 1, 2016. Medicare-eligible participants will be automatically enrolled in the **Chevron Senior Care Plan** 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 you should also refer to the **2016 Evidence of Coverage** document available for each plan to learn about additional changes not listed here. Contact the HMO directly to request a copy. You can find HMO contact information on [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) or by calling the HR Service Center.

## 2016 Medical HMO Plan Change Highlights

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### 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 retirees or active employees effective January 1, 2016. See Page 25 for more details.

# Mental Health and Substance Abuse Plan



When you and any of your covered dependents enroll in the **Medical PPO Plan** or the **High Deductible Health Plan**, mental health coverage is automatically provided by the Chevron Mental Health and Substance Abuse (MHSA) Plan administered by ValueOptions, as long as you aren't eligible for Medicare. If you are enrolled in the **Medicare Plus Plan, Medicare Standard Plan**, and the **Senior Care Plan**, there is no separate mental health coverage under the MHSA Plan since coverage is provided through Medicare. When you or any of your enrolled dependents become eligible for Medicare, mental health coverage under the MHSA Plan will stop for that person because Medicare provides this benefit. However MHSA coverage will continue for other participants as long as they aren't eligible for Medicare and continue to be enrolled in the Medical PPO or High Deductible Health Plans.

The MHSA plan provides confidential support for a wide range of personal issues – from everyday challenges to more serious problems. You and your covered dependents have access to support services 24 hours a day for a variety of concerns such as:

- Depression.
- Stress and anxiety.
- Parenting and family problems.
- Relationship difficulties.

## ValueOptions has merged with Beacon Health Options.

ValueOptions, the current administrator of your MHPA Plan, has merged with Beacon Health Strategies to form Beacon Health Options. There will be no changes to your MHPA Plan, other than a new logo and administrator name – **ValueOptions, a Beacon Health Options company**. Your MHPA benefits generally remain the same, with the exception of the 2016 plan design changes discussed in this newsletter.

- The **provider network** remains the same.
- The **phone number** remains the same.
- The **website address** remains the same.
- **ID cards** issued to *new* participants will reflect the new name and logo.

You will begin to see the Beacon name, logo and branding over time. For this reason, it's possible you may see some overlap of ValueOptions and Beacon Health Options branding. Providers have also started to see this change, so if your provider mentions it, there is no cause for concern.



**ValueOptions, a Beacon Health Options company**  
1-800-847-2438  
[www.valueoptions.com](http://www.valueoptions.com)

## New Office Visit Coinsurance Maximum

### Mental Health and Substance Abuse Plan Medical PPO (Option 1, Option 2) Participants Only

#### Mental Health Benefits

##### Outpatient

Office visit (individual, group, family, medication management).

*Some services require pre-certification (for example, psychological testing and electroconvulsive therapy).*

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##### Network

90% after 10% coinsurance (maximum \$25) per visit.

##### Out-of-Network

80% of allowed charges.

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#### Substance Abuse Benefits

##### Outpatient

Office visit (individual, group, family, medication management).

---

##### Network

90% after 10% coinsurance (maximum \$25) per visit.

##### Out-of-Network

80% of allowed charges.

---

# New Notification Requirements for Inpatient Admission

## Mental Health and Substance Abuse Plan

### All Eligible Participants

#### Mental Health Benefits

##### **Inpatient**

Acute inpatient treatment, structured outpatient treatment, intensive outpatient treatment, residential treatment and partial hospitalization.

*Some services require pre-certification (for example, psychological testing and electroconvulsive therapy).*

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All inpatient services require notification to ValueOptions within **3** business days of admission, or within **2** business days after an emergency hospital admission.

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#### Substance Abuse Benefits

##### **Inpatient**

Acute inpatient treatment, structured outpatient treatment, intensive outpatient treatment, residential treatment and partial hospitalization.

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You must notify ValueOptions within **3** business days of admission, or within **2** business days after an emergency hospital admission.

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# Medicare-Eligible?

## A Few Important Reminders

### Be sure you're enrolled in Medicare Part A and Part B.

All Medicare plans offered by Chevron require enrollment in both Medicare Part A and Part B. For Medicare-eligible retirees, Medicare is the primary payer of claims. This means your Chevron coverage will pay claims with the assumption that both Part A and Part B have paid their share of your charges, even if you aren't enrolled in or paying for Part B. So, if you aren't enrolled in Part B, you will be responsible for a much larger share of the cost for services, and in some cases, the total cost. If you aren't enrolled in Part B, you'll need to do so during the Medicare Part B general enrollment period from **January 1** through **March 31, 2016**. To enroll in Medicare, contact Social Security at **1-800-772-1213**. Your Part B coverage will become effective July 1, 2016. If you are newly eligible for Part B benefits, you should contact Social Security for information regarding how to enroll and the specific deadline that applies to you. More information about Medicare is available online at [www.medicare.gov](http://www.medicare.gov) or 1-800-MEDICARE (1-800-633-4227).

### Becoming Medicare-Eligible Due to Age or Disability

If you or your dependent will turn age 65 during 2016, you (or your dependent) will receive information and instructions from the HR Service Center about three months before the individual's 65th birthday. Be sure to read the package and take action by the deadlines. And if you don't receive this information, please contact the HR Service Center. If you or a dependent is under age 65 and become Medicare-eligible due to a disability, it's very important that you notify the HR Service Center. That's because Medicare is the primary payer of health care claims for Medicare-eligible retirees, survivors and dependents. You must be enrolled in a Chevron-sponsored plan that coordinates with Medicare or your reimbursement for services may be affected. For example, in certain situations you could be responsible for a large portion of the cost for services. So be sure to notify the HR Service Center (Page 6) right away if you become eligible for Medicare due to a disability.

### A reminder about health savings accounts.

As a reminder, if you have an existing **health savings account (HSA)** because you were enrolled in the Chevron High Deductible Health Plan (HDHP) or another permitted plan, don't forget about the strict rules surrounding contributions when you're eligible for Medicare. You can continue to contribute to an HSA as long as you're enrolled in a qualifying high deductible health plan *and you aren't enrolled in Medicare*. If you're no longer eligible to contribute to your HSA, you can still continue to use the funds in your account to pay for qualified health care expenses. When you turn 65, HSA funds can be used to pay certain insurance premiums, such as Medicare Part A, Medicare Part B, a Medicare HMO, or your share of retiree medical coverage offered by a former employer (like Chevron). You are responsible for understanding how an HSA works, qualified health care expenses, and determining if you're eligible to make contributions. You can read about the eligibility requirements at [www.irs.gov](http://www.irs.gov), *Publication 969* and about qualified expenses in *Publication 502*.



# Medicare Plus Plan Medicare Standard Plan Senior Care Plan

Chevron offers three medical plan options with UnitedHealthcare (UHC) as the claims administrator for Medicare-eligible retirees: **Medicare Plus Plan**, **Medicare Standard Plan** and the **Senior Care Plan**. See Page 42 for a brief comparison of the key similarities and differences among these plans.

## 2016 Monthly Cost Overview

Be sure to review the enclosed personal **enrollment worksheet** with your actual 2016 cost information, including the amount Chevron will contribute to your coverage, for the plans that apply to you. Chevron's company contribution for retiree coverage to all Medicare medical plans for 2016 will remain the same amount as for 2015.

Chevron currently shares the monthly cost of coverage - the premium - for your medical and dental plans. Our total premium cost is determined, in part, by the actual health care expenses incurred by the plans in the previous year. As a result of favorable health claims experience, the monthly premiums for these plans will *decrease* on average between **7%** to **11%**.

## Changes to Medical Coverage

Chevron will not make changes to medical coverage – including the deductible – for the **Medicare Plus Plan**, the **Medicare Standard Plan** or the **Senior Care Plan** in 2016.

## Changes to Prescription Drug Coverage

If you are enrolled in the **Medicare Plus Plan**, the **Medicare Standard Plan** or the **Senior Care Plan**, you will receive your Annual Notice of Changes for Express Scripts Medicare® (PDP) in the mail. This government-required mailing gives details about the changes to the prescription drug coverage through the Medicare Part D program administered by Express Scripts. It also includes the following documents:

- The **Express Scripts Medicare (PDP) Drug Formulary**. This document provides information about the drugs covered under your Medicare prescription drug coverage, including tier assignments.
- The **Express Scripts Medicare (PDP) Evidence of Coverage**. This document provides details about your Medicare prescription drug coverage.

Be sure to review these documents carefully to understand if there are any changes to your prescription drugs that might affect your costs. Keep these documents to reference them throughout the year. Copies are also available online at [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree). Contact

## Prescription Drug Copayments

Prescription drug copayments in the **Medicare Plus Plan**, the **Medicare Standard Plan** and the **Senior Care Plan** will generally remain the same in 2016. However, if the tier status of your drug has changed, your costs may change. Consult the Annual Notice of Changes for Express Scripts Medicare® (PDP) mailed to you to check applicable drugs.

## Prescription Drug Deductible

There is a separate deductible for prescription drugs under the **Medicare Plus Plan**, the **Medicare Standard Plan** and the **Senior Care Plan**. The prescription drug deductible for each plan will increase effective January 1, 2016.

### Medicare Plus Plan



**Deductible**  
Prescription Drugs  
**\$360** per person ↑

### Medicare Standard Plan



**Deductible**  
Prescription Drugs  
**\$360** per person ↑

### Senior Care Plan



**Deductible**  
Prescription Drugs  
**\$360** per person ↑

## Prescription Drug Out-of-Pocket Maximum

There is a separate out-of-pocket maximum for prescription drugs under the **Medicare Plus Plan**, the **Medicare Standard Plan** and the **Senior Care Plan**. The prescription drug out-of-pocket maximum for each plan will increase effective January 1, 2016.

### Medicare Plus Plan



#### Out-of-Pocket Maximum

Prescription Drugs\*

**\$4,850** per person (including deductible) ↑

### Medicare Standard Plan



#### Out-of-Pocket Maximum

Prescription Drugs\*

**\$4,850** per person (including deductible) ↑

### Senior Care Plan



#### Out-of-Pocket Maximum

Prescription Drugs\*

**\$4,850** per person (including deductible) ↑

*\* Once you reach the out-of-pocket maximum, the plan pays 95 percent of the remaining costs and you pay 5 percent, with a maximum not to exceed the standard cost-sharing amount during the initial coverage stage. See the Annual Notice of Changes for Express Scripts Medicare® (PDP) mailed to you for details.*



### Mental Health Coverage Reminder

Mental health services will count towards the deductible and out-of-pocket maximum for the **Medicare Plus Plan**, the **Medicare Standard Plan** and the **Senior Care Plan** outlined in the summary plan description.

# Medicare Medical HMO Plans

## Eligible for Medicare

A Medicare HMO option may be available to you in your area. The personal **enrollment worksheet** included in this open enrollment package will list any Medical HMOs available to you next year. Please review the information on the following pages to read about what's changing in 2016 for these plans.

Chevron's Medicare HMOs continue to include prescription drug coverage. **If you enroll in a Chevron Medicare HMO, you should not enroll in a separate Medicare prescription drug plan, because you cannot be enrolled in more than one Medicare Part D prescription drug plan.**

**In addition, if you're Medicare-eligible, you can't enroll in a Chevron Medicare HMO unless you have both Medicare Part A and Part B.** If you aren't enrolled in Part B, you'll need to enroll during the Medicare Part B general enrollment period from **January 1** through **March 31, 2016**. To enroll in Medicare, contact Social Security at **1-800-772-1213**. Your Part B coverage will become effective July 1, 2016. If you are newly eligible for Part B benefits, you should contact Social Security for information regarding how to enroll and the specific deadline that applies to you. More information about Medicare is available online at [www.medicare.gov](http://www.medicare.gov) or **1-800-MEDICARE (1-800-633-4227)**. Contact the Medicare HMO directly with questions about your coverage.

## 2016 Monthly Cost Overview

Be sure to review the enclosed personal **enrollment worksheet** with your actual 2016 cost information, including the amount Chevron will contribute to your coverage, for the HMO plans that apply to you (if any). Chevron's company contribution for retiree coverage to all Medicare medical plans for 2016 will remain the same amount as for 2015.

HMOs are products that Chevron purchases on behalf of our employees and retirees, and premiums are set by the HMOs based on their specific claims experience. Depending on the plan, the monthly premiums for some **Medicare Medical HMO** plans will *decrease* by approximately up to **15%**, while other plans will *increase* by approximately up to **26%**.

### Altius Health Plan Medicare Supplement Will Not Be Offered in 2016

This plan will no longer be available to retirees or active employees effective January 1, 2016. Retirees and their eligible dependents that are currently enrolled in this plan will be automatically enrolled in another Chevron medical plan for 2016. Participants not eligible for Medicare will be automatically enrolled in the **Medical PPO Plan - Option 1** effective January 1, 2016. Medicare-eligible participants will be automatically enrolled in the **Chevron Senior Care Plan** 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 Medicare HMO Plan Changes

If you participate in a Medicare 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 you should refer to the **2016 Evidence of Coverage** document available for each plan to learn about additional changes not listed here. Contact the Medicare HMO directly to request a copy. You can find Medicare HMO contact information on [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) or by calling the HR Service Center.

## 2016 Medicare Medical HMO Plan Change Highlights

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### Humana Group Medicare HMO

- Pharmacy *true out-of-pocket* (trOOP) increased to **\$4,850**.
  - For pharmacy catastrophic coverage, once the trOOP is met, the member is responsible for the greater of **\$2.95** for generic/multiple source drugs (**\$7.40** for all others), or **5%** coinsurance.
- 

### Health Plan Hawaii Medicare Supplement HI

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

### Kaiser Senior Advantage 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**.
- 

### Altius Health Plan Medicare Supplement

- This plan will no longer be available to retirees or active employees effective January 1, 2016. See Page 37 for more details.
-



## Medicare HMO Reminders

- Even if your current Medicare 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 Medicare HMO provider may have changed. Remember that HMOs require you to use doctors and hospitals that are part of their provider network. Contact your medical Medicare HMO directly to find out if your current providers continue to be in the network. If they aren't, you will need to change providers or choose a new plan to ensure that your medical services continue to be covered.
- Copayment and other changes in your current Medicare 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.





# Update to the Summary Plan Description

## Effective January 1, 2015

**All changes described in this SMM are effective January 1, 2015 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/retiree](http://hr2.chevron.com/retiree) 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 Your Chevron Benefits for Retirees 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.)

# 2015 Plan Changes

**This section describes the changes to your benefits that take effect on January 1, 2015.**

This section of the newsletter serves as an official summary of material modification (SMM) to the summary plan description (SPD) book(s) for the plans referenced herein. **Please keep this information with your other plan documents for future reference.** This SMM provides only certain information about changes of benefit provisions. It is not intended to be a complete explanation. If there are any discrepancies between this SMM and the legal plan documents, the legal plan documents will rule 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 get the summary plan descriptions for your benefits in two ways:

- **Online.** Visit [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) and choose the **Health and Welfare** tab.
- **By phone.** To request a printed free copy by mail, contact the HR Service Center at 1-888-825-5247 (inside the U.S.) or 610-669-8595 (outside the U.S.) and select Option 2.

- Page 12** Prescription Drug Changes
- Page 17** Medical and Dental HMO Plans
- Page 18** Medical PPO Plan – Option 1 and Option 2
- Page 20** Medical PPO Plan – Option 3
- Page 21** High Deductible Health Plan (HDHP)
- Page 26** Medicare Plus and Medicare Standard Plan
- Page 27** Senior Care Plan

# Prescription Drug Changes



## Changes for Medicare-Eligible Retirees

If you are enrolled in the **Medicare Plus Plan**, the **Medicare Standard Plan** or the **Senior Care Plan**, you should have already received your Annual Notice of Changes for Express Scripts Medicare® (PDP) in the mail. This government-required mailing gives details about the changes to the prescription drug coverage through the Medicare Part D program administered by Express Scripts. It also includes the following documents:

- **The Express Scripts Medicare (PDP) Drug Formulary.** This document provides information about the drugs covered under your Medicare prescription drug coverage, including tier assignments.
- **The Express Scripts Medicare (PDP) Evidence of Coverage.** This document provides details about your Medicare prescription drug coverage.

Be sure to review these documents carefully to understand if there are any changes to your prescription drugs that might affect your costs. For example, prescription drug copayments will generally remain the same in 2015, but if the tier status of your drug has changed, your costs may change. Keep these documents to reference them throughout the year. Copies are also available online at [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree).

## Changes for Retirees Not Eligible for Medicare

If you are enrolled in the **Medical PPO Plan** or the **High Deductible Health Plan (HDHP)**, you automatically have prescription drug coverage through the Prescription Drug Program with Express Scripts. The changes described below take effect on January 1, 2015. For additional details, contact Express Scripts Member Services at 1-800-987-8368, or review the documents and links available from [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree). Choose the **Open Enrollment** link to get started.

### New National Preferred Formulary

A formulary is a list of drugs that are covered by your plan. It includes commonly prescribed medications that have been selected based on their clinical effectiveness, safety and opportunities for savings. Effective January 1, 2015, your plan will switch to the National Preferred Formulary. While many of the same drugs will continue to be covered, there are approximately 65 drugs that will no longer be covered. See below for the list of drugs that will no longer be covered. If you continue to use any of these drugs, you will pay the full retail price when you refill that prescription starting January 1. If you are taking one of the drugs that will no longer be covered, Express Scripts will notify you starting in October. You will receive a personalized list of alternatives that are available on the formulary, so you can discuss them with your doctor and change your prescription in advance of January 1. An updated Medicare formulary is available on the **Open Enrollment** page of the [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) website. An updated formulary for retirees not eligible for Medicare is available by calling Express Scripts Member Services at 1-800-987-8368.

### Excluded Medications and Products Effective January 1, 2015

Abbott (FreeStyle, Precision)	Euflexxa	Nutropin/Nutropin AQ	Tev-Tropin
Abstral	Fentora	Omnaris	Tradjenta
Alvesco	Flovent Diskus/HFA	Omnitrope	Ultresa
Apidra	Follistim AQ	Pancreaze	Veltin
Aranesp	Fortesta	PegIntron	Veramyst
Axert	Frova	Pertzye	Victoza
Bayer (Breeze, Contour)	Gel-One	Proventil HFA	Vimovo
Beconase AQ	Hyalgan	Roche (Accu-Chek)	Vogelxo
BenzaClin Gel Pump	Incivek	Saizen	Xeljanz
Betaseron	Jentadueto	Simponi	Xopenex HFA
Bravelle	Kadian	Staxyn	Zetonna
Breo Ellipta	Kazano	Stendra	Zioptan
Cetraxal	Levitra	Subsys	Zohydro ER
Cimzia	Nesina	Supartz	
Duexis	Nipro (TRUEtest, TRUEtrack)	Tanzeum	
Edarbi/Edarbyclor	Novolin	Testim	
Epogen	NovoLog	Testosterone 1% Gel	
		Teveten HCT	

## Breast Cancer Risk-Reducing Medications

In accordance with the Health Care Reform law, your plan will provide network coverage at 100 percent with no deductible for certain breast cancer risk-reducing medication such as Tamoxifen and Raloxifene. You're eligible for the 100 percent coverage if you meet all of the following requirements:

- You are a woman age 35 or older.
- You do **not** have a prior history of a diagnosis of breast cancer, ductal carcinoma in situ (DCIS), or lobular carcinoma in situ (LCIS).
- You are being prescribed tamoxifen or raloxifene for the purpose of primary prevention of invasive breast cancer because you are deemed high risk.
- You are post-menopausal, if prescribed raloxifene (this does not apply to a woman prescribed tamoxifen).

Breast cancer risk-reducing medications that are covered are:

- Generic tamoxifen
- Generic raloxifene
- Brand Soltamox (tamoxifen liquid\*)

*\* Tamoxifen liquid will be covered at 100 percent with no deductible if the prescriber provides information that the patient meets all other criteria and cannot swallow or has difficulty swallowing tamoxifen tablets*

Coverage at 100 percent is not automatic. If you meet the eligibility criteria above, you or your provider must request the \$0 copayment/coinsurance within 30 days of the prescription being filled (pre- or post-fill). To request the \$0 copayment/coinsurance, follow these steps:

- You or your prescriber contacts Express Scripts Customer Service at 1-800-987-8368.
- Customer service will explain the procedure for contacting the Coverage Review Department through mail, fax, or a direct call transfer.
- You will submit your request through mail, fax or telephone.
- Your prescriber is contacted through a fax form to determine if you meet the eligibility criteria.
- Copayment review decision is then made.
- You and your prescriber are notified of decision.



## New Prior Authorizations

The Prescription Drug Program covers some drugs only if they're prescribed for certain uses or only up to certain quantity levels. For this reason, some medications must be approved in advance before you can receive plan benefits. The following drugs will require prior authorization effective January 1, 2015:

- Lovaza
- Vescepa (fish oil)

## Compound Medications Not Covered Without Prior Authorization

According to the FDA, compounding is the practice in which a licensed pharmacist combines, mixes or alters ingredients in response to a prescription to create a medication tailored to the medical needs of an individual patient. Individual active ingredients within the compound might be FDA approved, but the FDA does not approve the quality, safety and efficacy of a compound with multiple active ingredients. Express Scripts has identified 10 commonly used bulk powder ingredients (if submitted as the primary ingredient) that have limited or no medical studies for topical use. These bulk powders are:

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

**Beginning January 1, 2015, if you are using a compound medication in which the primary ingredient is one of the bulk powders listed above, the medication will no longer be covered without a Prior Authorization.** Approval for a Prior Authorization will require clinically sound studies proving the efficacy of the medication. Express Scripts recommends that you contact your physician to try a commercially available, FDA-approved alternative. For a few of the powders, there are commercially available products that don't require a compounded product. Only your medical provider and you can determine a suitable alternative since it is often difficult to determine the condition for which a compounded medication is being prescribed. If you continue to use the affected compounded medications without an approved Prior Authorization, you will pay the full retail price if you refill that prescription starting January 1. Express Scripts will continue to monitor this class of medications closely.



## Preferred Step Therapy Program Updates

Certain drugs are covered by the Prescription Drug Program only if preferred drugs - which include generics - are tried first. This is called Preferred Step Therapy (PST). The following are new additions to PST that will require you, when clinically appropriate, to try the preferred drug before Express Scripts will authorize coverage for the use of non-preferred drugs:

- **Gabapentin** (anticonvulsant and analgesic - pain relief - drugs): Lyrica, Horizant, Neurontin, Gralise
- **HMG** (statin drugs/cholesterol lowering drugs): Altoprev, Caduet, Lescol/Lescol XL, Lipitor, Livalo, Mevacor, Pravachol, Zocor
- **Beta Blockers** (blood pressure drugs): Bystolic, Sectral, Tenormin, Kerlone, Zebeta, Coreg, Coreg CR, Trandate, Lopressor, Toprol XL, Corgard, Levatol, Inderal, Inderal LA, InnoPran XL, Tenoretic, Ziac, Lopressor HCT, Corzide, Inderide, Dutoprol



# Medical and Dental HMO Plans

An HMO option may be available to you in your area. The personal enrollment worksheet included in this open enrollment package will list any HMOs available to you next year. All existing HMO plans will continue to be offered in 2015.

- **If you participate in an HMO offered by Chevron**, note that your provider or other plan features, like monthly premiums, copayments or prescription drug coverage could still change.
- **Even if your current HMO will be available in 2015**, 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 aren't, 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 2015 Evidence of Coverage document available for each plan. Contact the HMO directly to request a copy. You can find contact information on [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree).
- Chevron's Medicare HMOs continue to include prescription drug coverage. **If you enroll in a Chevron Medicare HMO, you should not enroll in a separate Medicare prescription drug plan, because you cannot be enrolled in more than one Medicare Part D prescription drug plan.**
- Chevron's Medical HMOs continue to include **mental health coverage**, whether or not you or your dependents are eligible for Medicare. These services are offered through the HMO, not ValueOptions.
- **Remember, if you're Medicare-eligible, you can't enroll in a Chevron Medicare HMO unless you have both Medicare Part A and Part B.** If you aren't enrolled in Part B, you'll need to enroll during the Medicare Part B general enrollment period from January 1 through March 31, 2015. To enroll in Medicare, contact Social Security at 1-800-772-1213. Your Part B coverage will become effective July 1, 2015. If you are newly eligible for Part B benefits, you should contact Social Security for information regarding how to enroll and the specific deadline that applies to you. More information about Medicare is available online at [www.medicare.gov](http://www.medicare.gov) or 1-800-MEDICARE (1-800-633-4227). Contact the HMO directly with questions about your coverage.

# Medical PPO—Option 1 and Option 2

## Option 1 Deductibles\*



### Medical

You Only	<b>\$300</b>
You + One Adult	<b>\$600</b>
You + Child(ren)	<b>\$600</b>
You + Family	<b>\$900</b>



### Prescription Drugs

You Only	<b>\$320 ↑</b>
You + Family	<b>\$640 ↑</b>



### Mental Health and Substance Abuse (MHSA) Plan

**\$0** There is no deductible for covered mental health and substance abuse services.

## Option 2 Deductibles\*



### Medical

You Only	<b>\$600</b>
You + One Adult	<b>\$1,200</b>
You + Child(ren)	<b>\$1,200</b>
You + Family	<b>\$1,800</b>



### Prescription Drugs

You Only	<b>\$320 ↑</b>
You + Family	<b>\$640 ↑</b>



### Mental Health and Substance Abuse (MHSA) Plan

**\$0** There is no deductible for covered mental health and substance abuse services.

\* For Option 1 and Option 2, each covered individual has a maximum deductible equal to the You Only deductible amount. For the You + One Adult, You + Child(ren) and You + Family coverage category levels, there is an overall maximum deductible amount for all covered participants that corresponds to the coverage category elected. No more than the You Only deductible amount can be applied toward the family deductible for any one person to satisfy the You + One Adult, You + Child(ren) or You + Family deductible.

### Option 1 Out-of-Pocket Maximum\*\*



#### Medical and Mental Health, Combined<sup>†</sup>

You Only	<b>\$2,300</b>
You + One Adult	<b>\$4,600</b>
You + Child(ren)	<b>\$4,600</b>
You + Family	<b>\$6,900</b>



#### Prescription Drugs

You Only	<b>\$1,800 ↓</b>
You + Family	<b>\$3,600 ↓</b>

### Option 2 Out-of-Pocket Maximum\*\*



#### Medical and Mental Health, Combined

You Only	<b>\$3,000 ↓</b>
You + One Adult	<b>\$6,000 ↓</b>
You + Child(ren)	<b>\$6,000 ↓</b>
You + Family	<b>\$9,000 ↓</b>

†



#### Prescription Drugs

You Only	<b>\$1,800 ↓</b>
You + Family	<b>\$3,600 ↓</b>

\*\* Generally includes your annual deductibles, copayments and coinsurance.

† The medical and mental health out-of-pocket maximums listed for Option 1 represent an increase for 2015 with respect to mental health services.

## Mental Health Coverage Reminder

When you and any of your covered dependents enroll in the **Medical PPO Plan**, mental health coverage is automatically provided by the Chevron Mental Health and Substance Abuse (MHSA) Plan administered by ValueOptions. When you or any of your enrolled dependents become eligible for Medicare, mental health coverage with the MHSA Plan will stop for that person because Medicare provides this benefit. However MHSA coverage will continue for other participants as long as they aren't eligible for Medicare and continue to be enrolled in the Medical PPO Plan. For more information about MHSA coverage, contact ValueOptions at 1-800-847-2438.

## Medical PPO – Option 3

**The Medical PPO – Option 3 plan choice will no longer be offered in 2015.** That's because this plan is being replaced by the new Chevron High Deductible Health Plan (HDHP) option. The Medical PPO – Option 1 and Medical PPO – Option 2 will continue to be offered to eligible retirees in 2015.

**If you are currently enrolled in the Medical PPO – Option 3, you will be automatically enrolled in the new Chevron High Deductible Health Plan starting January 1, 2015.**

If you would rather choose another plan, you must make an election during open enrollment, October 20 through October 31, 2014. Open enrollment is your only opportunity to change your 2015 medical coverage, unless you experience a qualifying life event later during the year.

### Make sure the HDHP is the right plan for you.

The new HDHP plan generally covers the same services as your current Medical PPO – Option 3 plan; however, there are important differences between your current plan and the HDHP that change how you will pay for your medical, prescription drug and mental health benefits in 2015. It's important that you pay attention to the differences and take the time to learn about the HDHP to ensure it's the right choice for you. Open enrollment is your only opportunity to change your 2015 medical coverage, unless you experience a qualifying life event later during the year. Be sure you don't miss this opportunity to learn, decide and act. See Page 21 to learn more about the HDHP.



# High Deductible Health Plan (HDHP)

## New Plan Choice Starting January 1, 2015



The Chevron HDHP is a new plan choice that will be offered in 2015. It is available to retirees and their dependents who are not enrolled in Medicare. The HDHP is a preferred provider organization (PPO) health plan that includes medical coverage with UnitedHealthcare, prescription drug coverage with Express Scripts, and Mental Health Substance Abuse coverage with Value Options. In addition, if you enroll in the HDHP, you're also automatically enrolled in the Vision Program for basic vision coverage with VSP. You can choose to see any provider you want; however, higher benefits are paid when go to a network provider.

With this plan you pay a low monthly premium in exchange for a high deductible. Participants enrolled in the HDHP may also be eligible to open and contribute to a health savings account (HSA).

## How the HDHP is Similar to Other Choices

Just like your other retiree medical options, Chevron currently shares the monthly cost of coverage - the premium - with you. This plan offers comprehensive coverage for the **same major medical services** you'd expect, including office visits, emergency services, hospital care, lab services, outpatient care, pregnancy and newborn care and rehabilitative services. It also includes **100 percent coverage with no deductible** for certain **preventive care services** as specified by the Affordable Care Act when you see a network provider. (100 percent of allowable charges for an out-of-network provider.) Additional preventive screenings and services may be covered, depending on factors such as your age and gender. If you are enrolled in the HDHP, you automatically have prescription drug coverage through the Prescription Drug Program with Express Scripts. (See Pages 12 for information about 2015 changes to the Prescription Drug Program.) For additional summary information about the new HDHP, such as benefits, copayments, deductibles, coinsurance and plan contact information, review the plan's Summary of Benefits and Coverage. (See Page 6.)

**Go to the Benefits Connection website (see Page 7) or review the enclosed personal enrollment worksheet to see the 2015 monthly premium costs for this and the other health plans that apply to you.**





## One Combined Deductible

Chevron's other medical plan choices typically require you to satisfy two deductibles before the plan pays its share of benefits: one for medical services and one for prescription drugs. The HDHP has only **one combined deductible** for medical, prescription drugs (both retail and mail-order), and mental health and substance abuse. And, it's a much higher deductible than your other Chevron medical plan choices. This means you'll have to pay the full cost for covered services and supplies until you reach the deductible for the year.

After you meet the deductible, coinsurance or copayments will apply. For example, this means you will pay the full cost for these covered services (and other covered services) until you meet your annual deductible:

- Retail prescriptions.
- Mail-order prescriptions.
- Visits to a mental health practitioner.
- Office visits to your doctor (except for certain preventive care as specified by the Affordable Care Act).
- Treatment for substance abuse.

### Annual Deductible\*

#### Medical, Prescription Drug, Mental Health Combined



You Only	<b>\$2,650</b>
You + One Adult	<b>\$5,300</b>
You + Child(ren)	<b>\$5,300</b>
You + Family	<b>\$7,950</b>




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

## One Combined Out-of-Pocket Maximum

The HDHP has only **one combined out-of-pocket maximum** for medical, prescription drugs, mental health and substance abuse. The out-of-pocket maximum is the most you will have to pay out-of-pocket for the year for covered services and supplies. When you reach this limit, the HDHP begins to pay 100 percent of the allowed amount for covered services and supplies.

### Out-of-Pocket Maximum\*

#### Medical, Prescription Drug, Mental Health Combined

			You Only	<b>\$5,000</b>
			You + One Adult	<b>\$9,000</b>
			You + Child(ren)	<b>\$9,000</b>
			You + Family	<b>\$12,900</b>

\* Generally includes your annual deductible, copayments and coinsurance.

### Understand how the combined deductible works.

If you choose the HDHP, you must be ready to pay the full amount of the higher deductible up front before the HDHP pays any benefits (except for certain preventive care as specified by the Affordable Care Act). You might already be familiar with this process because your current medical plan works the same way. **However, with the HDHP there are services that are now subject to the deductible which are typically excluded under your current plan.** This difference could surprise you, so we wanted to point them out in the event you use these services often. First, you'll pay full cost for retail and now also mail-order prescription drugs until you reach the single combined annual deductible. And under the current Medical PPO, mental health and substance abuse services *are* not subject to the deductible, so the Medical PPO shares the costs of those services right away. With the HDHP, mental health and substance abuse services are subject to the deductible, so you'll pay full cost for those covered services until you reach your single combined annual deductible.



## Health Savings Account (HSA) Compatible

If you enroll in the HDHP, you may also be eligible to open and contribute to a health savings account (HSA). An HSA is like a savings plan for health care. It works like a regular bank account, but you don't currently pay federal income taxes on money you deposit. And, under current IRS rules, when you use your money to pay for qualified health care expenses, you won't pay federal income taxes on the money either. Your savings grow from year to year. There is no use it or lose it rule. And you can take your money with you if you change medical plans. You can use an HSA to pay for qualified health care expenses this year, three years from now or at any point in the future.

It's your responsibility to learn about the strict eligibility rules and restrictions imposed by the IRS and determine if you meet the requirements to open and contribute to an HSA. You can choose from HSAs offered by any financial institution that offers them, including the Chevron Federal Credit Union, but it's up to you to find the one that meets your needs. In addition, you'll be responsible for understanding how an HSA works and making contributions.

Participating in an HSA is a voluntary choice. Chevron does not provide an HSA, and Chevron cannot offer counsel about HSAs. You should consult your financial advisor and read about the requirements in *IRS Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans* available at [www.irs.gov](http://www.irs.gov).

# Medicare Plus Plan

## Medicare Standard Plan

### Deductibles



Medical

**\$300** per person



Prescription Drugs

**\$320** per person ↑

### Out-of-Pocket Maximums



Medical

**\$1,500** per person (does not include deductible)



Prescription Drugs

**\$4,700** per person (including deductible) ↑

Once you reach the out-of-pocket maximum, the plan pays 95 percent of the remaining costs and you pay 5 percent, with a maximum not to exceed the standard cost-sharing amount during the initial coverage stage. See the Annual Notice of Changes for Express Scripts Medicare® (PDP) for details.

**Chevron offers three medical plan options with UnitedHealthcare (UHC) as the claims administrator for Medicare-eligible retirees: Medicare Plus Plan, Medicare Standard Plan and the Senior Care Plan. See Page 28 for a brief highlight of the key similarities and differences among these plans.**

# Senior Care Plan

## Medical Coverage



### Combined Deductible and Out-of-Pocket Maximum

Combined medical deductible and out-of-pocket maximum of **\$2,500** per person.

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## Prescription Drugs



### Deductible

**\$320** per person ↑

### Out-of-Pocket Maximum

**\$4,700** per person (including deductible) ↑

Once you reach the out-of-pocket maximum, the plan pays 95 percent of the remaining costs and you pay 5 percent, with a maximum not to exceed the standard cost-sharing amount during the initial coverage stage. See the Annual Notice of Changes for Express Scripts Medicare® (PDP) for details.



## Mental Health Coverage Reminder

If you are enrolled in the **Medicare Plus Plan**, **Medicare Standard Plan**, and the **Senior Care Plan**, there is no separate mental health coverage under the Mental Health and Substance Abuse (MHSA) Plan administered by ValueOptions since coverage is provided through Medicare. However mental health services will count towards the deductible and out-of-pocket maximum as outlined in the summary plan description.

# Eligibility and Participation

This section provides important information about participation in Chevron's health care plans for eligible retirees and eligible dependents.

- Who is Eligible to Participate
  - When and How You Can Enroll
  - Paying for Coverage
  - Making Changes
  - When Participation Begins
  - When Participation Ends
-

# Who is Eligible to Participate

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This section describes who's eligible for the retiree health benefit plans offered by Chevron. Note that each individual plan may have other specific eligibility requirements in addition to those described in this section. See each plan for additional eligibility requirements, if any.

You can participate in most of the retiree benefit plans offered by Chevron if you meet the qualifications of an "eligible retiree," as explained later in this section.

If you are an eligible retiree (or a surviving dependent of an eligible retiree), are under age 65, *aren't* eligible for federal Medicare, and live in an area where the plan is available, you can participate in:

- **The Medical PPO Plan** — a preferred provider organization (PPO) plan, which offers network and out-of-network benefits, includes coverage under the Prescription Drug Program and the Vision Program.
- **The Dental PPO Plan** — a preferred provider organization (PPO) plan, which offers network and out-of-network benefits.
- **A medical health maintenance organization (HMO)** offered by Chevron, where available. You may have a dental HMO option, too.

You can join the **Chevron Medicare Plus Plan**, the **Chevron Medicare Standard Plan** or the **Chevron Senior Care Plan** if you are an eligible retiree or dependent, are age 65 or older, and *are* eligible for federal Medicare — or if you're under age 65 and eligible for federal Medicare as a result of a disability. These plans include prescription drug coverage under the Express Scripts Medicare™ (PDP), a Medicare-approved prescription drug plan, and coverage under the Vision Program. Depending on where you live, you may be eligible for a Medicare Advantage HMO plan or a Medicare Supplement HMO plan. You may be eligible for a dental HMO, too. Chevron's HR Service Center can tell you which plans are available where you live.

You're automatically covered under the **Mental Health and Substance Abuse Plan** if you're an eligible retiree or dependent, you're enrolled in the Medical PPO plan, *and Medicare is not the primary payer of your medical benefits*.

## **If You Participate in a Medical or Dental HMO**

If you choose an HMO for your medical or dental coverage, you'll want to review the HMO or DHMO Supplement. This supplement gives you information about eligibility, participation and your legal rights as they specifically apply to a medical or dental HMO. For information about covered services, prescription drugs, supplies and treatment, as well as a list of HMO providers, you must contact your HMO.



## Eligible Retiree

If you retired on or after July 1, 2002, you and your eligible dependents are eligible for retiree medical and dental coverage if you're age 50 or older with 10 or more years of health and welfare eligibility service when you retire. Also, your last rehire date must have been at least five years before you retired, and you must not be a member of a union or group that was ineligible for retiree coverage.

If you left after June 30, 2002, and you didn't meet these qualifications, or if you do not meet the eligibility criteria discussed below, you aren't an eligible retiree. In addition, you may not be eligible if your employment with Chevron was terminated for misconduct, such as fraud, dishonesty or deliberate disregard of Chevron rules, or if you otherwise engage in misconduct during the course of your employment with Chevron.

### Health and Welfare Eligibility Service (HWES)

Your health and welfare eligibility service is used to determine your eligibility for retiree health care benefits. For more information about HWES, see the Company Contributions to Medical Coverage Supplement included in this summary plan description.

### If You Are a Former Chevron Employee Who Retired On or After July 1, 2002

If you retired at or after age 50 and had 10 or more years of health and welfare eligibility service, including five years of health and welfare eligibility service since your last rehire date, you're eligible for retiree medical coverage. You also are eligible for retiree dental coverage.

There is a special "grandfather" rule that allows eligibility under the above criteria **or** under the former Chevron rules. Under this grandfather rule, if you are a former Chevron employee and had at least 65 points (age plus years of continuous service) or at least 20 years of continuous service as of June 30, 2002, and you retired after completing at least 25 years of health and welfare eligibility service or after your age plus years of health and welfare eligibility service added up to 75 points or more, and you worked for Chevron immediately before retiring, you're eligible for medical coverage at 100 percent of the maximum company contribution. You also are eligible for retiree dental coverage.

### Note

Former Chevron employees are individuals who were employed by Chevron immediately before its merger with Texaco Inc. and who have not been terminated and rehired by Chevron since the merger with Texaco Inc.

**If You Are a Former Texaco Employee Who Retired On or After July 1, 2002**

If you retired at or after age 50 and had 10 or more years of health and welfare eligibility service, including five years of health and welfare eligibility service since your last rehire date, you're eligible for retiree medical coverage. You also are eligible for retiree dental coverage.

There is a special "grandfather" rule that allows eligibility under the above criteria **or** under the former Texaco rules. Under this grandfather rule, if you are a former Texaco employee and were age 45 or older and employed by Texaco as of October 1, 1999, you're eligible for retiree medical coverage under the former Texaco rules (that is, you retired at age 55 or older after completing at least 10 years of health and welfare eligibility service) at 100 percent of the maximum company contribution. You also are eligible for retiree dental coverage.

**Note**

Former Texaco employees are individuals who were employed by Texaco Inc. immediately before its merger with Chevron Corporation and who have not been terminated and rehired by Chevron since the merger with Texaco Inc.

Further, if you qualified for benefits under the Texaco Separation Pay Plan, you may be eligible for retiree medical coverage. For a copy of the *Texaco Separation Pay Plan Summary Plan Description*, please contact the Chevron HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.), option 2.

**If You Are a Former Texaco Employee Who Retired Before July 1, 2002**

For the most part, if you were considered a retiree or survivor with eligibility for health care benefits as of June 30, 2002, you also are eligible for at least some or all of the health plans available to retirees. Also, if you retired before July 1, 2002, your heritage company eligibility and cost-subsidy rules generally apply.

For instance, before July 1, 2002, dental coverage was only for those who retired from Chevron and for their dependents. Dental coverage is not available to former Texaco, former Getty, former Caltex, or former Amoseas employees who retired before July 1, 2002, or to their survivors.

Dental coverage is not available for those who retired from Gulf before July 1, 1986 or to their survivors.

**If You Are a Former Unocal Employee Who Retired On or After July 1, 2006**

If you retired at or after age 50 and had 10 or more years of health and welfare eligibility service, you're eligible for retiree medical coverage. You also are eligible for retiree dental coverage. You do not need to have five years of health and welfare eligibility service since your last rehire date.

If you qualified for certain benefits under the Unocal Termination Allowance Plan Change of Control benefits and/or the Special Continuation Coverage provision of the Unocal Medical Plan, you may be eligible for retiree medical coverage.

**Note**

Former Unocal employees are individuals who were employed by Unocal immediately prior to its merger with Chevron Corporation and who have not been terminated and rehired by Chevron since the merger with Unocal.

**If You Retired Before July 1, 2002**

For the most part, if you were considered a retiree or survivor with eligibility for health care benefits as of June 30, 2002, you also are eligible for at least some or all of the health plans available to retirees. Also, if you retired before July 1, 2002, your heritage company eligibility and cost-subsidy rules generally apply.

**If You Are a Former Unocal Employee Who Retired Before July 1, 2006**

For the most part, if you were considered a retiree or survivor with eligibility for health care benefits as of June 30, 2006, you also are eligible for at least some or all of the health plans available to retirees.

For instance, dental coverage was not offered under the former Unocal retiree health care program. Therefore, dental coverage is not available to former Unocal employees who retired before July 1, 2006, or to their survivors.

For information about company contributions to retiree medical coverage, see Appendix: Company Contributions for Retiree Health Care Coverage.

## Eligible Dependents

Generally speaking, if you're eligible and you enroll for coverage under one of the health plans offered by Chevron, you also must enroll your eligible dependents for coverage under the same health plan. This also applies if you have a family member who is Medicare-eligible and other family members who are not. For example, if the Medicare-eligible family member(s) is enrolled in the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, or the Chevron Senior Care Plan, then your non-Medicare family members must be covered under the Medical PPO Plan.

Eligible dependents include your spouse/domestic partner and eligible children (all defined below). (If you die, your surviving dependents who are enrolled at the time of your death may also be eligible for continued coverage under the health plans, as explained later under Eligible Survivors.)

### Note

If both you and your eligible spouse/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 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 health 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.

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

In general, if you die, your enrolled dependents are eligible for either continuation coverage or survivor coverage. For more information, see the Continuation Coverage and COBRA Coverage section in this summary plan description. If you retired before July 1, 2002, there may be special eligibility and cost rules for your enrolled surviving spouse, which may depend on the heritage company from which you retired. For example, per former Texaco's practice, survivors of Texaco retirees who retired before July 1, 2002, are eligible for the medical plans (not dental), but must pay the total cost of the medical plan after the retiree dies. When the Texaco survivor becomes Medicare-eligible, then the company pays 50 percent of the maximum company contribution.

### **Eligible Domestic Partner**

You can enroll your domestic partner for health plan coverage if you retired from Chevron after January 1, 1998, or if you retired from Chevron on or after July 1, 2002. (However, former Gulf, former Texaco, former Getty, former Caltex, and former Amoseas employees who retired before July 1, 2002, and former Unocal employees who retired before July 1, 2006, are not eligible to cover a domestic partner.)

To qualify for benefits available to domestic partners of Chevron retirees, 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 must be notarized and sent to the HR Service Center. By signing the affidavit, you certify that you and your partner meet one of the following qualifications:

1. You and your partner are all of the following:
  - At least age 18 and of legal age.
  - Mentally competent to enter into contracts.
  - Jointly responsible for each other's welfare and financial obligations and have lived together for at least six months prior to signing the affidavit.
  - In an intimate, committed relationship of mutual caring that has existed for at least six months prior to the signing of the affidavit and it is expected to continue indefinitely.
  - Not related by blood.
  - Not married to anyone other than each other.
2. You live in California and meet all of the requirements of the California Family Code section 297 definition of a domestic partner, including the requirement to have registered your domestic partner with the Secretary of State's office. For more information, visit the California Domestic Partnership website at [www.ss.ca.gov/business/sf/sf\\_dp.htm](http://www.ss.ca.gov/business/sf/sf_dp.htm).
3. You live in another state (such as Colorado, Delaware, Illinois, Nevada, New Jersey, Oregon, Rhode Island, Vermont, Washington, and others) that recognizes civil unions or state-recognized domestic partnerships and have entered into a civil union or state-recognized domestic partnership and reside in that state.
4. You and your partner have entered into a civil union in a state that recognizes civil unions, but reside in a state where that civil union is not recognized.
5. You meet other criteria set forth in the *Chevron Affidavit of Domestic Partnership*.

Note that you must enroll your domestic partner and his or her eligible children within 31 days of the date you first meet one of the qualifications 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.

Generally, you can enroll your registered domestic partner for medical and dental coverage under the same medical and dental plan 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.

If you die, your enrolled dependents are eligible for either continuation coverage or survivor coverage. For more information, see the Continuation Coverage and COBRA Coverage section and the Retiree and Survivor Coverage section in this summary plan description. If you retired before July 1, 2002, there may be special eligibility and cost rules for your enrolled surviving spouse, which may depend on the heritage company from which you retired.

### **Eligible Children and Other Dependents**

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

- You or your spouse's/domestic partner's natural child, step child, 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, contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).

In general, if you die, your enrolled dependents are eligible for either continuation coverage or survivor coverage. For more information, see the Continuation Coverage and COBRA Coverage section and the Retiree and Survivor Coverage section of this summary plan description. If you retired before July 1, 2002, there may be special eligibility and cost rules for your enrolled surviving spouse, which may depend on the heritage company from which you retired.

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

A QMCSO may be either a National Medical Support Notice issued by a state child support agency or an order or 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 in order 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.

### **Eligible Survivors**

Upon your death as a retiree, your enrolled dependents still may be eligible for health care coverage as survivors. If you retired before July 1, 2002, there may be special eligibility and cost rules for your enrolled surviving dependents, which may depend on the heritage company from which you retired. In all cases, survivors cannot add additional dependents without losing health care coverage. Further, if a survivor drops all health care coverage, he or she and any existing surviving dependents will not be allowed any future eligibility. For details, see When Participation Ends.



# When and How You Can Enroll

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

Before you retired, you were provided with information about how to continue health care coverage in retirement for yourself and your dependents. If you didn't elect to change health care coverage when you retired, you automatically continued to be covered under the plans in which you were enrolled, as long as the plans were available to retirees.

If you waive all health care coverage upon retirement or during one of Chevron's open enrollment periods, you can enroll in health care coverage during any subsequent open enrollment period. **However, if you're eligible for survivor coverage and you terminate all health care plan coverage, you become ineligible for coverage in the future.**

If you're enrolled in a health plan, you can switch coverage to another plan to which Chevron contributes (if you're eligible) during Chevron's open enrollment period. You can switch coverage without providing proof of good health.

The open enrollment period is usually held in the fall, with changes becoming effective the following January 1.

If you are employed with another company and you choose to be covered under that employer's benefits, you can waive your retiree health care coverage with Chevron. You can re-enroll in Chevron health care coverage during any subsequent open enrollment period or within 31 days of when your coverage with the other employer ends. If you die while covered under another employer's plan, your eligible dependent(s) who are covered under your plan on the date of your death can enroll in survivor coverage, provided the HR Service Center is notified within 31 days of your death.

If you're covered as a dependent under your spouse's health plan (non-Chevron coverage) and you become ineligible for that plan, you can enroll in a Chevron-sponsored health plan if you enroll within 31 days of the date the other coverage ends. (You will be required to provide proof that your other coverage ended.)

If your eligible dependents weren't enrolled when you retired, you can enroll them during the open enrollment period or within 31 days of the date they first became eligible.

If you acquire new dependents and they are to be covered under your health plans, you must enroll them within 31 days of the date they become eligible (as defined under Eligible Dependents in the Eligibility section); otherwise, you will have to wait until the open enrollment period to enroll your dependents, and their coverage will not be effective until the first of the following year.

You can enroll your dependents by contacting the HR Service Center or by accessing the Benefits Connection website at [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree).

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 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.), option 2.

## If You or a Covered Dependent Becomes Eligible for Medicare

### If You or a Covered Dependent Becomes Eligible for Medicare at Age 65

As a retiree, when you or one of your dependents becomes eligible for Medicare, you are required to select a plan that coordinates with Medicare if you have coverage with Chevron. The HR Service Center will send an enrollment package to you three months in advance of your (or your dependent's) 65th birthday. The package will describe the Medicare plan options available to you and instructions for enrollment. You will need to contact the HR Service Center to select a plan and provide your Medicare claim number. For some HMOs, you must complete an enrollment form. If there are Medicare-eligible and non-Medicare-eligible family members, your enrollment package will indicate the options available to you and your family members.

### If You or a Covered Dependent Becomes Eligible for Medicare Before Age 65

If you or a covered dependent receives Medicare benefits before age 65 due to a disability, you **must** notify the HR Service Center and send a copy of that person's Medicare card within 31 days of becoming eligible for Medicare. The HR Service Center will send you information about the health care options available to Medicare participants. If your current plan does not have a Medicare option, you will be able to select a plan that does offer Medicare coverage. When you or a dependent becomes eligible for Medicare, the plan will pay benefits as if you had Medicare as your primary payer of claims.

#### Note

To be covered under the Mental Health and Substance Abuse (MHSA) Plan, you and your dependents must not be eligible for Medicare and must be enrolled in the Medical PPO plan offered by Chevron. In addition, if you choose to enroll in one of the medical HMO options, you are not eligible for benefits under the Chevron Mental Health and Substance Abuse Plan. You should check your HMO's Evidence of Coverage to determine what mental health and substance abuse benefits may be available to you under your HMO plan. Also, former Gulf employees who retired before July 1, 1986, former Texaco, former Getty, former Caltex, and former Amoseas employees who retired before July 1, 2002, and former Unocal employees who retired before July 1, 2006, and their survivors, are not eligible for coverage under the Dental Plan or Dental HMO plans sponsored by Chevron.

Your Chevron medical coverage changes when you or your dependent(s) are eligible for Medicare. You or your dependents can become eligible for Medicare at age 65 (or earlier if receiving Social Security Disability.) When you or your eligible dependent is eligible for federal Medicare, Medicare becomes the primary payer for that person. Chevron medical plan coverage is secondary, which means it generally supplements what Medicare covers. When you become eligible for Medicare, you are no longer eligible for your current Chevron medical plan. However, you'll have a chance to choose a new Chevron medical plan option that coordinates with Medicare.

All medical plans offered by Chevron require enrollment in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance). If you or your dependent is eligible for Medicare and don't enroll, the benefits paid under your Chevron medical plan will be significantly reduced. That's because your Chevron plan automatically pays secondary to Medicare when you're eligible, even if you haven't enrolled in Medicare. That means that you could be responsible for a large portion of the cost for services, and in some cases, the total cost.

### **Important Reminders When You're Eligible for Medicare**

- If your spouse or domestic partner has medical coverage as an employee or retiree through another employer, you should check with that employer to determine how that medical coverage is affected upon becoming eligible for Medicare.
- Medicare does not cover or pay for medical services received outside the U.S. If you're living outside the U.S. when you become Medicare eligible, contact the HR Service Center for more information about what to expect regarding your Chevron medical coverage.
- **If you're Medicare-eligible, enrolling in a non-Chevron medical plan could cause you to lose your Chevron coverage.** Medicare will not allow you to be covered under more than one Medicare HMO or Medicare Part D Prescription Drug Plan (PDP). Your Chevron medical and prescription drug coverage will be cancelled if you enroll in a non-Chevron sponsored health plan that may offer Medicare prescription drug coverage (even if you choose a medical-only option). It's always your choice to decide which medical coverage is best for you. But, if you wish to keep your Chevron retiree medical and prescription drug coverage, do not enroll in a non-Chevron sponsored Medicare health plan (including a group plan offered through your spouse's employer).

# Paying for Coverage

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You and Chevron currently share the cost of your benefit plans. For more information, see Appendix: Company Contributions for Retiree Health Care Coverage.

## How You Pay for Coverage

If you're receiving a pension check from Chevron, you can elect to have your contributions for health (and life insurance) coverage deducted from your check each month, provided the amount of your check is sufficient to cover the deductions.

Otherwise, you're billed one month in advance for your coverage. Bills are mailed by the 9th business day of each month. Payment is due on the first of the following month. If you wish, you can make payments several months in advance. You can pay your contribution by personal check or you can choose to have your monthly payments deducted automatically from your checking or savings account ("direct debit").

If you choose direct debit, you must authorize the HR Service Center to deduct your monthly payments from your bank account. These deductions are made from your account no sooner than the 15th of the month to cover your premiums for the following month. If you choose this option, you will *not* receive a monthly payment coupon from the HR Service Center. Instead, you will need to refer to your bank account statement for verification of the debit. If you want to sign up for direct debit, contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.) and select option 2, then option 6.

If your payment is not received within 30 calendar days from the due date, your coverage will be terminated retroactive to the last day of the month in which the payment was made. For example, your October payment must be received by October 31; otherwise, your coverage will be terminated retroactive to September 30.

### Example

- You're billed for April coverage on March 13.
- Payment for your April coverage is due by April 1.
- If your payment for April coverage isn't received by April 1, a bill for both your April and May coverage will be sent on April 13.
- Payment for your April and May coverage is due by May 1.
- If payment for April coverage isn't received by May 1, your coverage will be cancelled retroactive to March 31.

There is a one-time, per lifetime, reinstatement policy (for any reason) if you miss a payment or make a late payment, provided that you appeal within 60 days of the cancellation date and you agree to the direct (electronic) debit billing method on an ongoing basis.

If you have already used your one-time reinstatement, you may appeal to the HR Service Center for another reinstatement. However, the guidelines for this second reinstatement are very stringent.

Please note that if you are a retiree, you are able to re-enroll at open enrollment each October for coverage in the following year. If you are a survivor, you will **not** have the opportunity to re-enroll if reinstatement is **not** approved and coverage is cancelled.

If you have questions about direct debit or the billing process, contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.) and select option 2, then option 6.

**Where Do I Send My Payments?**

If you are paying for your coverage by personal check, send your payments to:

Xerox for Chevron  
Box 382064  
Pittsburgh, PA 15251-8064

**Overnight Address:**

Xerox for Chevron  
Attn: 382064  
500 Ross Street 154-0460  
Pittsburgh, PA 15251-8064

# Making Changes

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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.

Here's a brief explanation of changes you can make:

- You can switch to another medical or dental plan (available in your area) during open enrollment held in the fall, or if you move out of the service area for the plan in which you're currently enrolled. You can change your dependent coverage elections during open enrollment or within 31 days of a qualifying life event (the change must be consistent with the qualifying event). You also can change your medical or dental elections during the year if you or a dependent qualifies for special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- If you're enrolled in the Medical PPO plan offered by Chevron, you and your enrolled dependents are automatically covered under the Mental Health/Substance Abuse Plan. There are no elections to change under this plan.

## 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 retiree health plan option for which you are eligible or, if you're already enrolled in a health plan option, you may change health plan options if another option is available.

## Special Enrollment Due to Loss of Other Coverage

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

- COBRA continuation coverage that has since ended.
- Coverage (if not COBRA continuation coverage) that has since terminated due to a "loss of eligibility," a loss of employer contributions, or for the other reasons described below.
- "Loss of eligibility" includes a loss of coverage due to any of the following:
  - Legal separation.
  - Divorce.
  - Death.
  - Ceasing to be a dependent as defined by the terms of a plan.
  - Termination of employment.
  - Reduction in the number of hours of employment.

Loss of eligibility 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:

- 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 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.

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

- **Required length of special enrollment:** You and your dependents must request special enrollment in writing no later than 31 days from the day the other coverage was lost.
- **Effective date of coverage:** If you enroll within the 31-day period, coverage takes effect the first day of the month after the other coverage ended.

## Special Enrollment Due to New Dependent Eligibility

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

- **Nonenrolled retiree:** If you're eligible but haven't yet enrolled, you can enroll upon your marriage, upon acquiring a new domestic partner, or upon the birth, adoption or placement for adoption of your child.
- **Nonenrolled spouse/domestic partner:** If you're already enrolled, you can enroll your spouse/domestic partner at the time of your marriage or acquiring a new domestic partner. You also can enroll your spouse/domestic partner if you acquire a child through birth, adoption or placement for adoption.
- **New dependents of an enrolled retiree:** 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 retiree:** 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 retiree) 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 Plan Information** chapter, **Free or Low-Cost Health Coverage to Children and Families** section of this summary plan description.

# When Participation Begins

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## Retiree Coverage

Generally, your health plan participation continues without interruption as soon as you became an eligible retiree (as defined in the Eligibility section), unless you elected to cancel coverage at retirement. When you or a dependent becomes eligible for Medicare, coverage for the participating person changes to a Medicare plan, generally on the first day of the month in which that person's 65th birthday occurs (unless your or your dependent's birth date is the first day of the month, then Medicare coverage is effective the first of the preceding month).

## Dependent Coverage

Health plan coverage for your eligible, enrolled dependents (as defined in the Eligibility section) was continued without interruption as soon as you became an eligible retiree, unless you elected to cancel your coverage and/or their coverage at retirement. Eligible newborn children become covered on their date of birth, if you enroll them within 31 days of the date they're born. A newly adopted child becomes covered on the date of adoption or (if earlier) on the date the child is placed with you for adoption, if you enroll the child within 31 days. For other eligible dependents, such as a new spouse/domestic partner and new children or a new stepchild other than your newborn or newly adopted children, coverage begins on the first day of the month after they become eligible, if you enroll them within 31 days.

## Open Enrollment

If you switch to another health plan during the open enrollment period or enroll in retiree coverage after waiving it, coverage under the new plan begins the following January 1.

## When Participation Ends

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Your retiree health plan coverage ends on the last day of the month in which any of the following occurs:

- You cancel your coverage.
- You stop making required contributions.
- You're re-employed by Chevron.
- Chevron Corporation terminates the plan.

Your dependents' coverage ends on the last day of the month in which any of the following occurs:

- They're no longer eligible.
- You cancel their coverage.
- You stop making required contributions.
- Chevron Corporation terminates the plan.

When you or your dependent becomes Medicare-eligible, coverage under your or your dependent's current plan will end. You (or your dependent) will then become eligible to join the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, the Chevron Senior Care Plan, or a Medicare Advantage HMO if available in your area. **Note:** The Chevron Medicare Plus Plan is not available to Unocal retirees who retired before July 1, 2006.

When you become Medicare-eligible, you will receive an enrollment package that outlines your new coverage options. If there are Medicare-eligible and non-Medicare-eligible family members, your enrollment package will indicate the options available to you and your family members. Coverage under the Mental Health/Substance Abuse Plan will continue for all non-Medicare-eligible members, but will terminate for Medicare-eligible family members.

If you move out of your health plan's service area, you must change to a plan offered where you live. Your new coverage will be effective on the first day of the following month.

You can be in only one Medicare prescription drug plan at a time. If you enroll in a Medicare Advantage (MA) plan that includes Medicare Prescription drug coverage, your Chevron medical and prescription drug coverage will be terminated. In addition, you cannot be enrolled in an individual MA Plan – even one without prescription drug coverage – at the same time as you are enrolled in a Chevron-sponsored Medicare health plan.

There are other circumstances when participation for you or your dependents may end. For instance, participation for any covered individual ends if the company terminates the plan.

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).

## **If you or a dependent is hospitalized when coverage ends**

If you or a dependent is hospitalized at the time coverage under the Medical PPO Plan ends, benefits for certain covered charges incurred in the hospital can be paid until you or your dependent leaves the hospital.

## **If, as a retiree, you die**

Your enrolled dependents may be eligible for either continuation coverage or survivor coverage. For more information, see the Continuation Coverage and COBRA Coverage section and the Retiree and Survivor Coverage section under Administrative Information. Chevron may pay a portion of the cost of this survivor coverage. While these plan rules determine health care benefit eligibility for your survivors, 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.

If a surviving spouse/domestic partner or dependent waives all health plan coverage or if coverage ends for any reason, including nonpayment of premium, they become permanently ineligible for future health plan coverage and coverage will not be reinstated.

## **COBRA**

Under the terms of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (see the Continuation Coverage and COBRA Coverage section for details), you and your eligible dependents may be able to continue coverage after your regular retiree coverage ends.

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# Medical PPO Plan

This section provides a description of the Medical PPO Plan for you and your eligible dependents. This section includes a description of the following components of this plan:

- Medical Coverage – UnitedHealthcare (UHC)
- Prescription Drug Program – Express Scripts
- Basic Vision Coverage - VSP Vision Care (VSP)

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

- Medical coverage, with UnitedHealthcare (UHC) as the claims administrator.
- Prescription drug coverage, with Express Scripts as the claims administrator.
- Basic vision coverage insured by VSP.

Depending on where you live, you may be eligible for a medical health maintenance organization (HMO) plan. If you choose an HMO for your medical coverage, you'll want to review the Medical and Dental HMO Supplement of this summary plan description. That section gives you information about eligibility, participation and your legal rights. For information about covered services, prescription drugs, supplies and treatment, as well as a list of HMO providers, contact your HMO.

**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.**



# Medical Coverage

## Chevron Medical PPO

UnitedHealthcare (UHC) is the claims administrator of medical benefits under the Medical PPO. You and your eligible dependents have this medical coverage if you are enrolled in the Medical PPO. This section describes the medical benefits under the plan.



# Overview

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- The plan is a preferred provider organization (PPO). This means the plan has a network of health care providers available in many locations.
- Your out-of-pocket costs are lower when you receive care from a network provider. You always have the option of using an out-of-network provider, but your out-of-pocket costs will be higher when you do.
- You have to pay the required deductible before many plan benefits can be paid.
- A feature of the plan is the out-of-pocket maximum, which limits your out-of-pocket costs.
- The three coverage options are: Option 1, Option 2 and Option 3.
  - Option 1 has a lower deductible and lower out-of-pocket maximum but a higher monthly premium than Option 2.
  - Option 2 has a higher deductible and higher out-of-pocket maximum but a lower monthly premium than Option 1.
  - Option 3 has the lowest monthly premium but a higher deductible and higher out-of-pocket maximum than Options 1 and 2.
- The only differences between Options 1 and 2 are the out-of-pocket maximum, the deductible requirement and the monthly premium; otherwise, the benefits are the same. Unlike Options 1 and 2, there are no copayments in Option 3. In Option 3, you share the costs with the plan through coinsurance. All three options cover the same kinds of health care. In addition, all three options include the same Prescription Drug Program and vision benefits.

# How the Plan Works

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

## If You Go to a PPO Network Provider

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

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

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

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

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

## Special Provision for Alaska Retirees

Eligible participants with a permanent home address in Alaska (and their covered dependents) will receive the network level of coverage, applied to the billed charges, for services received in Alaska. For instance, if a participant who resides in Alaska incurs covered charges in Alaska that are generally covered on an in-network basis at 90% of the contracted fees, such charges will be covered at 90% of billed charges. Services received outside of Alaska will be reimbursed based on their network status, either in-network or out-of-network. For example, if you reside in Alaska and you obtain services on a business trip or vacation to Houston, Texas and use an out-of-network provider for an office visit, the plan will reimburse 80 percent of allowable charges. This provision does not apply to vision or prescription drug benefits.

## If You Go to Certain UnitedHealthcare Out-of-Network Providers

The plan offers a discount if you use an out-of-network hospital, medical facility, doctor or other health care professional who is affiliated with MultiPlan. With this discount, your out-of-pocket costs are “mid-level” — higher than if you use network providers, but lower than if you use other unaffiliated out-of-network providers.

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

To find an out-of-network provider affiliated with MultiPlan, call 1-800-654-0079 or access the website at [www.myuhc.com](http://www.myuhc.com). Click on **Physicians and Facilities** and select **Find Shared Savings Physicians & Facilities**. (In order to use the provider search tool for the Shared Savings feature, you must be a registered user and log in to the myuhc.com website.)

### Provider

A hospital, medical or health care facility, doctor, dentist or other health professional licensed where required, performing within the scope of that license.

- A PPO (preferred provider organization) participating provider or network provider has agreed to charge discounted rates for services provided to plan members. To encourage you to use these providers, the plan often pays a higher benefit rate for network services. Also, you generally don’t have to file a claim form when you go to a PPO network provider. You can obtain a list of network providers in your area by contacting UnitedHealthcare.
- A non-PPO, nonparticipating provider or an out-of-network provider does not have an agreement with the claims administrator pertaining to the payment of covered services for a member.

### Contracted Fees

**UnitedHealthcare** defines contracted fees as the amount a participating provider agrees to accept as payment in full for covered services. Contracted fees are usually lower than the provider’s normal charge.

## **Nurse Advisor Team**

A team of registered nurses with UHC is available as part of your plan benefit. The Nurse Advisor Team is dedicated solely to Chevron. You can call a Nurse Advisor with questions or concerns for health matters big and small. A Nurse Advisor can help you with condition management (for example diabetes or asthma), understanding an illness, an upcoming hospitalization, major surgery or treatment options. They can also help you understand and follow your doctor's treatment plan and self-care suggestions, provide you with educational materials and individualized support, find doctors or other health care professionals in the network as well as connect you with community resources. You can contact a nurse 24 hours a day, seven days a week at 1-800-654-0079. If you would like more information about Nurse Advisor services you can visit UHC's website at [www.myuhc.com/groups/cvx](http://www.myuhc.com/groups/cvx), select Member Guide and Nurse Advisor Program.

## **Pre-Service Review**

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

## **Claims Administrator**

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

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

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

## Deductibles

The Medical PPO Plan has three coverage options. All three options cover the same kinds of health care; however, each option has different deductibles, annual out-of-pocket maximums, and monthly premiums.

Your deductible is the amount of covered health care charges (defined later in this section) you pay for combined network and out-of-network care and services each calendar year before the plan begins paying its share of those charges.

Annual Deductible	Option 1	Option 2	Option 3
<b>You Only</b> (with retail prescription drugs subject to a separate deductible)	\$300	\$600	\$2,500
<b>You and One Adult</b> (with retail prescription drugs subject to a separate deductible)	\$600	\$1,200	\$5,000
<b>You and Child(ren)</b> (with retail prescription drugs subject to a separate deductible)	\$600	\$1,200	\$5,000
<b>You and Family</b> (with retail prescription drugs subject to a separate deductible)	\$900	\$1,800	\$7,500

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

For example, if you choose the “You and Family” coverage tier for Option 1, your annual deductible is satisfied when the family’s accumulation of deductibles reaches \$900, with no more than \$300 applied for each family member. Your family could meet the \$900 deductible with charges of \$300 for one member, \$300 for a second member, \$150 for a third member and \$150 for a fourth member.

Your deductible expenses don't count toward the plan's out-of-pocket maximum. And, the following expenses don't count toward your deductible:

- Copayments.
- Charges in excess of contracted fees for services provided by network providers and charges in excess of allowable charges for services provided by out-of-network providers.
- Charges for services or supplies that aren't medically necessary.
- Charges for services and supplies that aren't covered under the plan.
- Your share of the cost of vision care expenses.
- Your share of the cost of medication purchased under the plan's Prescription Drug Program (prescription drugs are subject to a separate deductible).
- Additional expenses you pay because you don't follow the plan's Health Care Review procedures.
- Additional expenses you pay above certain benefit limits, such as expenses for durable medical equipment, temporomandibular joint dysfunction (TMJ) and wigs.
- Your share of the cost for services and supplies under the Mental Health/Substance Abuse Plan.

#### **Covered Charges (Medical PPO Plan)**

The plans pay only for health services that are medically necessary and appropriate for the diagnosis and treatment of sickness or injury, and for certain preventive care services. Benefits paid for these services provided by out-of-network providers are based on allowable charges for the service or supply provided. You have to pay for services and supplies that aren't covered under the plan. And, if you go to an out-of-network provider, you must pay any charges in excess of allowable charges. If you go to a PPO network provider for care, plan benefits are based on the discounted rates ("contracted fees") the provider charges, instead of on allowable charges. Covered charges can be either the contracted fees you are charged by a network provider or the allowable charges for an out-of-network service or supply.

## Out-of-Pocket Maximum Feature

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After you pay your deductible, the plan pays a percentage of covered charges for the care you need, and you pay any costs above the amount paid by the plan.

Under this feature, after your out-of-pocket costs reach the specified amount for the coverage tier, the plan pays 100 percent of all covered charges until the end of the calendar year.

Annual Out-of-Pocket Maximum Feature	Option 1	Option 2	Option 3
You Only	\$2,300	\$3,600	\$4,200
You and One Adult	\$4,600	\$7,200	\$8,400
You and Child(ren)	\$4,600	\$7,200	\$8,400
You and Family	\$6,900	\$10,800	\$12,600

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

For example, if you choose the “You and Family” coverage tier for Option 1, your annual out-of-pocket maximum is met when the family’s accumulation of out-of-pocket costs reaches \$6,900, with no more than \$2,300 applied for each family member. Your family could meet the \$6,900 maximum limit with charges of \$2,300 for one member, \$2,300 for a second member, \$1,150 for a third member and \$1,150 for a fourth member.

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

- Charges in excess of contracted fees for services provided by network providers and charges in excess of allowable charges for services provided by out-of-network providers.
- Charges for services or supplies that aren't medically necessary.
- Charges for services or supplies that aren't covered under the plan.
- Your share of the cost of vision care expenses.
- Your share of the cost of medication purchased through the plan's Prescription Drug Program.
- The Prescription Drug Program deductible.
- Additional expenses you pay because you don't follow the plan's Health Care Review procedures.
- Additional expenses you pay above certain benefit limits, such as expenses for durable medical equipment.
- Your share of the cost for services and supplies under the Mental Health/Substance Abuse Plan.



## What the Plan Pays

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

### Acupuncture

Options 1 and 2	
Network	100% of contracted fees after a \$25 copayment, no deductible, for office visits up to a maximum of 20 visits per calendar year (combined network and out-of-network visits)
Out-of-Network	80% of allowable charges after deductible for office visits up to a maximum of 20 visits per calendar year (combined network and out-of-network visits)
Option 3	
Network	90% of contracted fees after deductible for office visits up to a maximum of 20 visits per calendar year (combined network and out-of-network visits)
Out-of-Network	80% of allowable charges after deductible for office visits up to a maximum of 20 visits per calendar year (combined network and out-of-network visits)

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

### Allergy Treatment

Options 1 and 2	
Network	100% of contracted fees after a \$25 copayment, no deductible, for office visits; 90% of contracted fees after deductible for treatment in an outpatient facility
Out-of-Network	80% of allowable charges after deductible
Option 3	
Network	90% of contracted fees after deductible
Out-of-Network	80% of allowable charges after deductible

The plan helps pay for allergy testing and treatment, including the injection and cost of allergy serum. Under Options 1 and 2, if you receive allergy treatment (for example, allergy injections) at a provider's office without a doctor's office visit charge, the plan pays 100 percent of charges with no copayment and no deductible.

**Ambulance Transportation**

	<b>Options 1, 2 and 3</b>
Emergency	<p><b>Network:</b> 90% of contracted fees after deductible</p> <p><b>Out-of-network:</b> 90% of billed charges after deductible</p>
Nonemergency	<p><b>Network:</b> 90% of contracted fees after deductible</p> <p><b>Out-of-network:</b> 80% of allowable charges after deductible</p>

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

**Birth and Newborn Charges**

	<b>Options 1, 2 and 3</b>
Network	100% of contracted fees, no deductible, for doctor services; 90% of contracted fees after deductible for facility charges
Out-of-Network	80% of allowable charges, no deductible, for doctor services; 80% of allowable charges after deductible for facility charges

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

- Hospital room and board for you and your baby (the healthy baby is not subject to his or her own deductible while initially in the hospital after delivery).
- Inpatient care for you.
- Inpatient well-baby care (including routine nursing care, pediatrician services and miscellaneous tests).
- Services provided by doctors and nurses during delivery.
- Hospital services and supplies.
- Licensed birthing center (limited to \$1,000 per pregnancy).
- A circumcision performed within 28 days of the birth, whether performed in or out of the hospital.

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

- More than 48 hours after a normal delivery.
- More than 96 hours after a cesarean delivery.

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

**Note:** See the Life Events SPD for a checklist of things to think about when you have a new baby.

### Birthing Centers

	Options 1, 2 and 3
Network	90% of contracted fees, no deductible, to a maximum of \$1,000 per pregnancy
Out-of-Network	80% of allowable charges, no deductible, to a maximum of \$1,000 per pregnancy

The plan covers maternity- and pregnancy-related services provided at an approved birthing center, such as room and board and miscellaneous supplies and services, including anesthetics and their administration. A birthing center is a facility that operates under the license of a hospital and provides a home-like setting under a controlled environment for the purpose of childbirth. If you choose a midwife or nurse-midwife who is supervised by a network doctor, these services are covered at 90 percent of contracted fees after the deductible. If the midwife is supervised by an out-of-network doctor, services are covered at 80 percent of allowable charges after the deductible. Home delivery is not covered under the plan.

### Chiropractic Care

Options 1 and 2	
Network	100% of contracted fees after a \$25 copayment, no deductible, for office visits; 90% of contracted fees, no deductible, for treatment in an outpatient facility; up to a maximum of 20 visits per calendar year (combined network and out-of-network visits)
Out-of-Network	80% of allowable charges after deductible for office visits or treatment in an outpatient facility; up to a maximum of 20 visits per calendar year (combined network and out-of-network visits)
Option 3	
Network	90% of contracted fees after deductible for office visits or treatment in an outpatient facility; up to a maximum of 20 visits per calendar year (combined network and out-of-network visits)
Out-of-Network	80% of allowable charges after deductible for office visits or treatment in an outpatient facility; up to a maximum of 20 visits per calendar year (combined network and out-of-network visits)

The plan covers the services of a doctor or chiropractor for the detection or correction (manipulation), by manual or mechanical means, of structural imbalance or distortion in the spine. The plan pays benefits only for therapy services given by a licensed or certified provider acting within the scope of that license or certification.

### Clinical Trials – Office Visits\*

Options 1 and 2	
Network	100% of contracted fees after a \$25 copayment per visit, no deductible.
Out-of-Network	80% of allowable charges after deductible.
Option 3	
Network	90% of contracted fees after deductible.
Out-of-Network	80% of allowable charges after deductible.

### Clinical Trials – Hospital Care\* (inpatient and outpatient)

Options 1, 2 and 3	
Network	90% of contracted fees after deductible.
Out-of-Network	80% of allowable charges after deductible.

**\*Note** – review the Hospital Care and Office Visit sections for additional coverage information

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

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

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

### Cochlear Implants

	Options 1, 2 and 3
Network	90% of contracted fees after deductible
Out-of-Network	80% of allowable charges after deductible

The plan pays covered charges for services and supplies, including implantable components, for bilateral or unilateral cochlear implantation where required due to profound prelingual, perilingual or postlingual bilateral sensorineural hearing loss in children and when due to profound postlingual bilateral sensorineural hearing loss in adults (This includes adults who were initially diagnosed with prelingual or perilingual bilateral sensorineural hearing loss and who have progressed to severe to profound postlingual bilateral sensorineural hearing loss). Cochlear implantation not described above, including unilateral or bilateral cochlear implants in adults when due to prelingual or perilingual sensorineural hearing loss, and cochlear hybrid implants, are not covered. The external components for covered implantation (i.e., speech processor, microphone, and transmitter coil) are considered durable medical equipment (DME) – see the Durable Medical Equipment chart. Post Cochlear Therapy is covered under the plan (learning to use the device, adjust to hearing with it). The plan will pay only for a single purchase (including repair or replacement) for cochlear implants once every three years.

### Colonoscopy

	Options 1, 2 and 3
Network	100% of contracted fees for preventive colonoscopies; 90% of contracted fees after deductible for routine colonoscopies
Out-of-Network	100% of allowable charges for preventive colonoscopies; 80% of allowable charges after deductible for routine colonoscopies

The plan covers colonoscopies recommended by your physician, including those performed as a preventive screening. General anesthesia for this procedure is not covered unless determined by UnitedHealthcare to be medically necessary.

### Dental Care

	Options 1, 2 and 3
Network	90% of contracted fees after deductible
Out-of-Network	80% of allowable charges after deductible

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

- Dentists' charges for the repair or initial replacement of sound, natural teeth that are damaged or lost as a result of an accident other than a chewing injury. Services must begin within three months and be completed within 12 months of the date of the accident. (You must notify UnitedHealthcare's Personal Health Support before receiving services in a hospital.)
- Oral surgery to correct fractures and dislocations resulting from an accident; services must begin within three months and be completed within 12 months of the date of the accident.(You must notify UnitedHealthcare's Personal Health Support before receiving services in a hospital.)
- Oral surgery for tumors and cysts of the mouth, except for those caused by diseases of the teeth or gums.
- Oral surgery to control a medical condition other than TMJ, such as osteomyelitis, cleft palate, burns and orthognathic surgery, which are within the mouth but not tooth- or gum-related.
- Facility and anesthesia charges for any of the covered procedures or when necessary due to an underlying medical condition.

**Surgical TMJ Treatments**

The plan helps pay for oral surgery for treatment of temporomandibular joint dysfunction (TMJ).

**Other TMJ Treatments**

	<b>Options 1, 2 and 3</b>
Network	50% of contracted fees after deductible up to a lifetime maximum of \$1,000 (combined network and out-of network)
Out-of-Network	50% of allowable charges after deductible up to a lifetime maximum of \$1,000 (combined network and out-of network)

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

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

	<b>Options 1, 2 and 3</b>
Network	90% of contracted fees after deductible
Out-of-Network	90% of billed charges after deductible

The plan pays covered charges for emergency room care, radiology, anesthesia and pathology services. To make sure you qualify for full benefits, you or your doctor must notify UnitedHealthcare within two business days after an emergency hospital admission. If you don't follow the Health Care Review procedures, benefits paid for your emergency care may be reduced to 60 percent of covered charges.

### Family Planning Services

	Options 1, 2 and 3
Network	90% of contracted fees after deductible
Out-of-Network	80% of allowable charges after deductible

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

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

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

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

Charges related to surrogate parents and charges incurred by a sperm or egg donor are not covered. Included are doctor-prescribed contraceptives that require insertion by a doctor or significant doctor follow-up, such as injectable contraceptives, morning-after pills, implants (for example, Depo-Provera or Levonorgestrel), IUDs, diaphragms, other removable devices and related office visits. Oral contraceptives are covered under the Prescription Drug Program. Over-the-counter supplies are not covered.



**Gender Identity Disorder — Hospital Care\* (inpatient and outpatient)**

	<b>Options 1, 2 and 3</b>
Network	90% of contracted fees after deductible.
Out-of-Network	80% of allowable charges after deductible.

**Gender Identity Disorder — Office Visits\***

	<b>Options 1 and 2</b>
Network	100% of contracted fees after a \$25 copayment per visit, no deductible.
Out-of-Network	80% of allowable charges after deductible.
	<b>Option 3</b>
Network	90% of contracted fees after deductible.
Out-of-Network	80% of allowable charges after deductible.

*\*Note – review the Hospital Care and Office Visit sections for additional coverage information.*

The plan pays benefits for the treatment of gender identity disorder for inpatient and outpatient benefits as follows below. **Before beginning treatment, your provider must notify Personal Health Support at UHC.**

- Continuous hormone replacement (hormones of the desired gender).
- Surgery to change the genitalia and specified secondary sex characteristics, specifically:
  - Thyroid chondroplasty (reduction of the Adam's Apple).
  - Bilateral mastectomy.
  - Augmentation mammoplasty if the physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role.
- Laboratory testing to monitor the safety of continuous hormone therapy.

**For hormone replacement, you must meet all of the following:**

- Age 18 years or older. Demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks.
- The definition of Gender Identity Disorder as shown in the Glossary.
- Initial hormone therapy must be preceded by either of the following.
  - A documented real-life experience of at least three months prior to the administration of hormones.
  - A period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months).

**For genital surgery and surgery to change secondary sex characteristics, you must meet all of the following:**

- The physician who is performing the surgery must notify Personal Health Support at UHC prior to performing the surgery.
- The surgery must be performed by a qualified provider at a facility with a history of treating individuals with gender identity disorder.
- Your treatment plan must conform to the World Professional Association for Transgender Health Association (WPATH) standards; not all WPATH standards are covered under the plan. If you have questions, please call the customer services number on your ID card.
- You are age 18 years or older.
- You have completed 12 months of continuous hormone therapy for those without contraindications.
- You have completed 12 months of successful, continuous, full-time real-life experience in the desired gender.

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

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

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

## Hearing Aids

	<b>Options 1, 2 and 3</b>
Network	90% of contracted fees after deductible
Out-of-Network	90% of allowable charges after deductible

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

## Hearing Aids

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

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

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

## Home Health Care

	<b>Options 1 and 2</b>
Network	100% of contracted fees, no deductible, up to a maximum of 60 visits (combined network and out-of-network visits)
Out-of-Network	70% of allowable charges, no deductible, up to a maximum of 60 visits (combined network and out-of-network visits)
	<b>Option 3</b>
Network	90% of contracted fees after deductible, up to a maximum of 60 visits (combined network and out-of-network visits)
Out-of-Network	70% of allowable charges after deductible, up to a maximum of 60 visits (combined network and out-of-network visits)

Any combination of network and out-of-network benefits is limited to 60 visits per calendar year. One visit equals four hours of skilled home health care services. The plan pays covered charges for medical services provided in your home by a home health care agency. No benefits are payable for custodial care. Services received from an approved home health care agency must be both of the following:

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

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

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

UnitedHealthcare decides if skilled home health care is required by reviewing both the skilled nature of the service and the need for doctor-directed medical management. A service is not determined to be “skilled” simply because there is not an available caregiver. **To receive full plan benefits, remember to notify UnitedHealthcare’s Personal Health Support before services begin.**

## Hospice Care

<b>Options 1 and 2</b>	
Network	90% of contracted fees, no deductible
Out-of-Network	80% of allowable charges, no deductible
<b>Option 3</b>	
Network	90% of contracted fees after deductible
Out-of-Network	80% of allowable charges after deductible

These benefits are payable whether covered care is provided in an approved hospice facility or in the patient's home. To receive full plan benefits, you should notify UnitedHealthcare's Personal Health Support before services begin. Hospices offer an alternative to hospital care for the treatment of terminally ill patients. These programs also provide counseling for the families of the terminally ill.

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

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

## Hospice — Bereavement Counseling

<b>Options 1 and 2</b>	
Network	50% of contracted fees, no deductible, for up to 15 visits
Out-of-Network	50% of allowable charges, no deductible, for up to 15 visits
<b>Option 3</b>	
Network	50% of contracted fees after deductible, for up to 15 visits
Out-of-Network	50% of allowable charges after deductible, for up to 15 visits

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

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

**Hospital Care (inpatient and outpatient)**

	<b>Options 1, 2 and 3</b>
Network	90% of contracted fees after deductible
Out-of-Network	80% of allowable charges after deductible

If you have preadmission testing (other than surgical testing), such as laboratory and X-ray work, performed at the same hospital before inpatient surgery, these tests are covered at 100 percent for both contracted network and allowable out-of-network covered charges; no deductible applies. Surgical testing for inpatient or outpatient surgery is covered at 90 percent of contracted fees or 80 percent of allowable charges, both after the deductible. The plan covers charges for the following hospital services and supplies:

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

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

To make sure you qualify for full hospitalization benefits, you or your doctor must notify UnitedHealthcare to request a Health Care Review three or more business days before you're admitted to the hospital for network or out-of-network hospitalization or within two business days after an emergency admission. If you don't follow the plan's Health Care Review procedures, benefits paid for your hospital care (either network or out-of-network) are reduced to 60 percent of covered charges.

**The following applies for both network and out-of-network childbirth services:**

*No approval or preauthorization for maternity admissions is needed from UnitedHealthcare. In accordance with the Newborns' and Mothers' Health Protection Act of 1996, the plan may not restrict benefits for a mother's or newborn child's hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, the law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable). Note that authorization must be obtained from the UnitedHealthcare for a length of stay in excess of these periods. For a description of benefits, see the Birth and Newborn Charges chart under What the Plan Pay in this section.*

### Lab Tests and X-Rays

	Options 1, 2 and 3
<b>Network</b> (inpatient and outpatient)	90% of contracted fees after deductible, regardless of where the service is performed
<b>Out-of-Network</b> (inpatient and outpatient)	80% of allowable charges after deductible, regardless of where the service is performed

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

### Medical Supplies and Equipment

	Options 1, 2 and 3
Network	90% of contracted fees after deductible
Out-of-Network	80% of allowable charges after deductible

- The plan helps pay covered charges for the purchase of needed medical supplies and equipment, including:
  - Casts, splints, dressings, braces and crutches.
  - Ostomy supplies.
  - Intravenous (IV) infusion therapy supplies.
  - Prosthetic devices, such as breast prostheses, artificial limbs and eyes to initially replace natural body parts, and their subsequent repair and replacement if they malfunction, limited to a single purchase of each type of prosthetic device once every three years.
  - Initial pair of eyeglasses or contact lenses, including fitting, following surgery or accidental injury to the lens of an eye.
  - Glucometers (the plan also pays covered charges for diabetic testing supplies, but under the Prescription Drug Program).
  - Orthopedic shoes and needed modifications to the shoes, if shoes are part of a medically necessary brace.
- Durable medical equipment, including:
  - Equipment to assist mobility, such as a standard wheelchair.
  - A standard hospital-type bed.
  - Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and mask).
  - Delivery pumps for tube feeding (including tubing and connectors).
  - Braces that stabilize an injured body part (including necessary adjustments to shoes to accommodate braces), but dental braces are excluded from coverage.
  - Mechanical equipment necessary for the treatment of chronic or acute respiratory failure, but air conditioners, humidifiers, dehumidifiers, air purifiers, air filters and personal comfort items are excluded from coverage.
  - External components (such as speech processor, microphone, and transmitter coil) of covered cochlear implants.



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

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

**Non-U.S. Medical Services**

The plan will reimburse you at the out-of-network percentage level of billed charges after you meet the deductible for medically necessary treatments and services incurred outside the United States. Emergency services will be reimbursed at the network percentage level of billed charges after you meet the deductible. Notification or authorization is not required for services received outside the United States. However, the plan will not reimburse you for services and supplies that do not meet the definition of a covered charge or if the services and supplies were obtained outside the United States because you were or would be denied coverage for such services and supplies within the United States.

**Office Visits**

Generally, except where noted:

<b>Options 1 and 2</b>	
Network	100% of contracted fees after a \$25 copayment per visit, no deductible
Out-of-Network	80% of allowable charges after deductible
<b>Option 3</b>	
Network	90% of contracted fees after deductible
Out-of-Network	80% of allowable charges after deductible

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

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

### Organ and Tissue Transplants

	Options 1, 2 and 3
Network	90% of contracted fees after deductible
Out-of-Network	80% of allowable charges after deductible

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

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

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

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

### Organ and Tissue Transplants: Transportation and Lodging

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

- Plan reimbursements for transportation and lodging are available only if the patient is using an approved network transplant facility.
- The plan pays for transportation of the patient and one companion, who is traveling on the same day(s) to and from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- The plan pays reasonable and necessary expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to \$50 for one person or up to \$100 per day for all family members combined. If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered, and lodging will be reimbursed up to the \$100 per diem rate for all family members combined.
- Travel and lodging expense reimbursement is available only if the transplant recipient resides more than 50 miles from the approved network transplant facility.

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

Donor charges are covered only if the recipient of the organ/tissue transplant is covered under this plan. UnitedHealthcare will assist the patient and family with travel and lodging arrangements.

### Podiatry Services

	<b>Options 1 and 2</b>
Network	100% of contracted fees after a \$25 copayment, no deductible, for office visits; 90% of contracted fees, no deductible, for treatment in an outpatient facility
Out-of-Network	80% of allowable charges after deductible for office visits or treatment in an outpatient facility
	<b>Option 3</b>
Network	90% of contracted fees after deductible for office visits or treatment in an outpatient facility
Out-of-Network	80% of allowable charges after deductible for office visits or treatment in an outpatient facility

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

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

### Prenatal Care

Options 1 and 2	
Network	100% of contracted fees after a \$25 copayment for the first visit (to confirm pregnancy), no deductible
Out-of-Network	80% of allowable charges, after deductible.
Option 3	
Network	100% of contracted fees, no deductible
Out-of-Network	80% of allowable charges, after deductible.

After the pregnancy is confirmed, the plan pays 100 percent of covered charges for a network doctors' office visits and associated tests for the sole purpose of prenatal care after conception but before the baby is born. This also includes tests prescribed by a network doctor, such as amniocentesis and sonograms. When performed solely to learn the sex of the unborn child, an amniocentesis is not covered.

Expectant mothers can participate in a special education program called the Healthy Pregnancy Program. To enroll in or learn more about this voluntary program, call UnitedHealthcare at 1-800-654-0079. UHC's Healthy Pregnancy Program is provided at no charge to you and gives you the following:

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

### Preventive Care

Options 1 and 2	
Network	100% of contracted fees, no deductible.
Out-of-Network	100% of allowable charges, no deductible.
Option 3	
Network	100% of contracted fees, no deductible
Out-of-Network	100% of allowable charges, no deductible

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

### Private-Duty Nursing

	Options 1, 2 and 3
Network	90% of contracted fees after deductible, up to 1,000 hours or 120 days per calendar year (whichever comes first)
Out-of-Network	80% of allowable charges after deductible, up to 1,000 hours or 120 days per calendar year (whichever comes first)

If your doctor prescribes private-duty nursing care outside the hospital, be sure to contact UnitedHealthcare in order to receive full plan benefits. You must notify UnitedHealthcare's Personal Health Support at least five business days before you or a dependent begins receiving private-duty nursing services; otherwise, the benefit is reduced to 60 percent. **The plan will not pay benefits for private-duty nursing in a hospital or skilled nursing facility** because it is not considered medically necessary since hospitals provide adequate nursing services. Custodial care isn't covered by the plan, even if it's prescribed by a doctor and provided by a nurse.

### Rehabilitation Therapy (inpatient)

	Options 1, 2 and 3
Network	90% of contracted fees after deductible, up to a maximum of 120 visits per calendar year (combined network and out-of-network visits)
Out-of-Network	80% of allowable charges after deductible, up to a maximum of 120 visits per calendar year (combined network and out-of-network visits)

Benefits are available for services and supplies received during an inpatient stay in an inpatient rehabilitation facility, including room and board in a semiprivate room (a room with two or more beds).

In general, the intent is to provide benefits for members who are convalescing from an injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services that are less than those available in a general acute hospital but greater than those available in the home setting. The patient is expected to improve to a predictable level of recovery.

Benefits are available when rehabilitation services are needed on a daily basis and, accordingly, benefits are not available when these services are required intermittently (such as physical therapy three times a week). However, coverage for therapies on intermittent frequencies may be covered under other plan benefits.

Benefits are not available for custodial, domiciliary or maintenance care (including administration of enteral feeds). This care is not covered, even if it is ordered by a doctor, if it is for the primary purpose of meeting personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

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

### Rehabilitation Therapy (outpatient)

	Options 1, 2 and 3
Network	90% of contracted fees after deductible, up to a maximum of 30 visits per calendar year (combined network and out-of-network visits)
Out-of-Network	80% of allowable charges after deductible, up to a maximum of 30 visits per calendar year (combined network and out-of-network visits)

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

### Skilled Nursing Facility Care

	Options 1, 2 and 3
Network	90% of contracted fees after deductible, up to 120 calendar days (combined network and out-of-network)
Out-of-Network	80% of allowable charges after deductible, up to 120 calendar days (combined network and out-of-network)

After you pay the deductible, the plan pays a percentage of covered charges for care in an approved skilled nursing facility for up to 120 days each calendar year (combined network and out-of-network).

If a doctor prescribes the care in a skilled nursing facility and you or your enrolled dependent would otherwise be cared for in a hospital (and the care is not custodial), the plan pays covered charges for the following services and supplies:

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

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

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

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

### **Surgery**

Generally, except where noted:

	<b>Options 1, 2 and 3</b>
Network	90% of contracted fees after deductible
Out-of-Network	80% of allowable charges after deductible

If you need to be hospitalized for an operation, you or your doctor must notify UnitedHealthcare in order to receive the full benefits provided by the plan. If it is not an emergency, you should call three business days before surgery is performed. If it is an emergency, you should call within two business days after emergency surgery is performed.

If you have any preadmission testing (other than surgical testing), such as laboratory and X-ray work, performed before a hospital admission for scheduled inpatient surgery, the testing is covered at either 100 percent of contracted fees (network) or 100 percent of allowable charges (out-of-network) with no deductible. The tests must be performed in the same hospital in which the surgery will be performed. Surgical testing for inpatient or outpatient surgery is covered at the usual 90 percent of PPO contracted fees (network) or 80 percent of allowable charges (out-of-network) after the deductible.

The Medical PPO plan can help pay covered charges for:

- Surgeons' services (including charges for any medically necessary assistant surgeon or standby surgeon).
- The maximum allowable covered medical expense for an assistant surgeon is 16 percent of the contracted fees (network) or 16 percent of the allowable charges (out-of-network) for the surgical procedure performed. The plan then reimburses that amount at 90 percent of contracted fees (network) or 80 percent of allowable charges (out-of-network) after the deductible.
- Anesthesia supplies and the services of an anesthesiologist.
- Hospital operating and recovery rooms, and services and supplies associated with the surgery.

- Ambulatory surgical center operating and recovery rooms, and services and supplies associated with the surgery.
- Outpatient surgical procedures.
- Certain organ and tissue transplants, when ordered by a doctor.
- Certain reconstructive surgery.
- Second and third surgical opinions.

#### *Multiple Surgical Procedures*

After you pay the deductible, the plan pays 90 percent of contracted fees (network) for multiple surgical procedures. If more than one surgical procedure is performed during any one operative session, reimbursement for out-of-network surgeons' services will be based on the allowable amount, which is 100 percent of covered charges for the primary procedure and 50 percent of covered charges for each additional procedure.

For example, let's say the primary procedure's allowable charge is \$100. Let's also assume that the secondary procedure has an allowable charge of \$100. The reimbursement for the secondary procedure will be based on \$50 (50 percent of \$100). If your deductible has been met and the coinsurance is 80 percent, the plan will pay \$120 (80 percent of \$150) and you will pay \$80 (\$200 – \$120).

#### *Reconstructive Surgery*

The plan covers reconstructive surgery under the following conditions:

- To improve the function of a body part when the malfunction is the direct result of a birth defect, sickness, surgery to treat a sickness or accidental injury, or an accidental injury.
- To remove scar tissue on the neck, face or head, if scar tissue is due to sickness or an accidental injury.
- Following a mastectomy, as well as reconstruction of the other breast to produce a symmetrical appearance. Coverage also is provided for prostheses and for treatment of physical complications at all stages of the mastectomy, including lymphedemas.



### *Second and Third Surgical Opinions*

Second and third surgical opinions are used to determine whether the surgery is medically necessary and are covered at 100 percent of contracted fees (network) or 100 percent of allowable charges (out-of-network) with no deductible. The second or third opinion must be obtained from a board-certified surgeon who is not the surgeon originally scheduled to perform the surgery. Covered charges include:

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

### **Therapy Treatments**

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

#### **Therapy Treatments: Physical, Occupational, and Speech Therapy**

	<b>Options 1 and 2</b>
Network	100% after a \$25 copayment, no deductible, for office visits; 90% of contracted fees, no deductible, for therapy performed in an outpatient facility; up to a maximum of 90 visits per calendar year (combined network and out-of-network visits for physical, occupational and speech therapies).
Out-of-Network	80% of allowable charges after deductible for office visits or treatment in an outpatient facility; up to a maximum of 90 visits per calendar year (combined network and out-of-network visits for physical, occupational and speech therapies).
	<b>Option 3</b>
Network	90% of contracted fees after deductible for office visits or treatment in an outpatient facility; up to a maximum of 90 visits per calendar year (combined network and out-of-network visits for physical, occupational and speech therapies ).
Out-of-Network	80% of allowable charges after deductible for office visits or treatment in an outpatient facility; up to a maximum of 90 visits per calendar year (combined network and out-of-network visits for physical, occupational and speech therapies)

### *Physical Therapy*

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

### *Occupational Therapy*

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

### *Speech Therapy*

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

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

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

### Therapy Treatments: Orthoptic Therapy

Options 1 and 2	
Network	100% after a \$25 copayment, no deductible, for office visits; 90% of contracted fees, no deductible, for therapy performed in an outpatient facility; up to a maximum of 30 visits per calendar year.
Out-of-Network	80% of allowable charges after deductible for office visits or treatment in an outpatient facility; up to a maximum of 30 visits per calendar year.
Option 3	
Network	90% of contracted fees after deductible for office visits or treatment in an outpatient facility; up to a maximum of 30 visits per calendar year.
Out-of-Network	80% of allowable charges after deductible for office visits or treatment in an outpatient facility; up to a maximum of 30 visits per calendar year.

#### *Orthoptic Therapy*

Outpatient services for orthoptic therapy are covered. The plan pays benefits only for orthoptic therapy services given by a licensed or certified provider acting within the scope of that license or certification. Orthoptic therapy is an individualized treatment program prescribed to eliminate or improve conditions such as amblyopia (lazy eye), strabismus (crossed eyes), focusing, eyeteaming and tracking disorders. Inpatient services for orthoptic therapy are covered as inpatient hospital benefits. For additional benefits, see Rehabilitation Therapy (inpatient) and Rehabilitation Therapy (outpatient) in this section.

# Expenses That Aren't Covered

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The Medical PPO Plan does not cover the following:

- Services or supplies provided during times you or your covered dependents were not covered under the plan.
- Services and supplies that do not meet the definition of a covered charge.
- Charges in excess of the plan's allowable charges.
- Charges for services, supplies, procedures, and treatments that are not medically necessary.
- With respect to a network provider, charges in excess of the contracted rate.
- Confinement, treatment, services, and supplies given for or related to any of the following:
  - Abdominoplasty.
  - Liposuction.
  - Speech therapy, except when it is specifically listed in "covered charges" as defined in the plan, for fluency disorders.
  - Chelation therapy, except to treat heavy metal poisoning.
  - Tobacco dependency, except as specifically covered by the Mental Health/Substance Abuse Plan and/or the Prescription Drug Program.
  - Massage therapy, including, but not limited to, Rolfing.
  - Membership costs for health clubs, purchase of home whirlpools, spas, and saunas for any reason.
  - Tine test for tuberculosis.
  - Herbal medicine and holistic or homeopathic care, including, but not limited to, drugs, aromatherapy, and ecological or environmental medicine.
  - Personal convenience or comfort items or general household goods, including, but not limited to, the purchase or rental of radios, TVs, telephones, first-aid kits, exercise equipment, air conditioners, humidifiers, food liquefiers, newspapers, bedside tables, or the cost for meals for guests.
- Charges for broken appointments, completing or processing claim forms, telephone conversations, consultations, or Internet consultations.
- Cosmetic or reconstructive surgery or procedures, except reconstructive surgery that's specifically covered under the plan.

- Physical appearance:
  - Cosmetic surgery or treatment (surgery or treatment primarily to change appearances), whether or not for psychological or emotional reasons, including confinement, treatment, services or supplies, including:
    - Cosmetic procedures.
    - Pharmacological regimens.
    - Nutritional procedures or treatments (including gastric bypass).
    - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
    - Skin abrasion procedures performed as a treatment for acne.
    - Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure. Note: Replacement of an existing breast implant is considered reconstructive rather than cosmetic if the initial breast implant followed a mastectomy.
    - Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation.
    - Weight reduction or control, whether or not they are under medical supervision (such as Jenny Craig™ and Weight Watchers™). Membership costs for weight-loss clinics and similar programs and special foods, food supplements, liquid diets, diet plans, or other related products.
    - Wigs, toupees, hair transplants, hair weaving, or any drug if the drug is used in connection with baldness, regardless of the reason for the hair loss, including congenital alopecia (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury).
    - Medical and surgical treatment of excessive sweating (hyperhidrosis).
    - Obesity surgery (unless accompanied by a diagnosis of morbid obesity with a body mass index (BMI) of either 35–39.9 (with co-morbidities) or 40 (with no co-morbidities)).
- Treatment of benign gynecomastia (abnormal breast enlargement in males).
- Medical and surgical treatment for snoring and appliances that prevent snoring (except when provided as a part of treatment for documented obstructive sleep apnea).
- Custodial care.
- Eye refractions (vision screenings), eyeglasses, contact lenses and other vision-related supplies, services and procedures, except as specifically covered by the plan's vision benefit or unless required by an accidental injury; surgical procedures to correct refraction errors of the eyes (for example, LASIK or PRK), including any confinement, services or supplies given in connection with, or related to, the surgery, are excluded; (see the Basic Vision section).
- Hearing aids or cochlear implants (except as specifically covered under the Medical PPO plan) and dental prosthetic appliances, other than when required in connection with temporomandibular joint dysfunction (TMJ), or the fitting of any of these supplies, unless required by an accidental injury (see Dental Care in this section).

- Services provided by any person who is a member of your immediate family or who resides in your home.
- Charges related to surrogate parents.
- Charges incurred by a sperm or egg donor.
- Elective amniocentesis or other tests performed solely to learn the sex of the unborn child.
- Home delivery of a newborn child.
- Treatment in a U.S. government or agency hospital. However, the reasonable cost incurred by the U.S. or one of its agencies for inpatient medical care and treatment given by a hospital of the uniformed services may be covered under the plan. The cost of this inpatient medical care and treatment will be covered if the charges for the care and treatment are otherwise covered under this plan and the care and treatment were provided to any of the following:
  - A person retired from the uniformed services.
  - A family member of a person who is retired from the uniformed services.
  - A family member of a person who is active in the uniformed services.
  - A family member of a deceased member of the uniformed services.
- Expenses that you, yourself, are not legally required to pay. However, the reasonable cost incurred by the U.S. for medical care and treatment given to a veteran by the U.S. or one of its agencies may be covered under the plan. The cost of the care and treatment will be covered if:
  - The veteran does not have a service-related disability.
  - Charges for the care and treatment are otherwise covered under the plan.
- Treatment or services provided by a government facility or doctor, or payable under a government plan or program, except as required by law.
- Treatment of an injury or other loss that results from a patient's active participation in any of the following:
  - An insurrection or riot.
  - A crime, unlawful act or attempted crime.
  - War or any act of war (declared or undeclared) or international armed conflict or conflict involving armed forces of any international authority.
- Treatment of an injury or other loss that results from service in the armed forces of any government or international authority.
- Charges for services that aren't considered acceptable or appropriate by the general medical community.
- Services given by a pastoral counselor (except as provided under Hospice Care in What the Plan Pays in this section).

- Private-duty nursing services while confined in a hospital or other facility.
- Services or supplies in connection with organ or tissue transplants, except as specifically provided by the plans (see Organ and Tissue Transplants in What the Plan Pays in this section).
- Education, training, and bed and board in an institution that is primarily a school, or other institution for training or a place of rest, or a domicile for the aged.
- Auxiliary items normally available without a prescription, even though they're recommended by a doctor (including items such as posture chairs, hot tubs, exercise bicycles and other exercise equipment).
- Routine physical exams required for insurance, licensing, employment, school, camp or other nonpreventive purposes.
- Any tests required for a marriage license.
- Equipment for environmental control or general household use (such as air conditioners and food liquefiers).
- Immunizations for travel outside the U.S. or for occupational requirements.
- Payments for which you're reimbursed or are eligible to receive reimbursement as a result of any award or settlement from a third party for medical expenses resulting from an act or failure to act of the third party — including reimbursements under no-fault automobile insurance — unless you or your dependent agrees to reimburse the plan when damages are recovered from the third party.
- Examinations or treatment ordered by a court in connection with legal proceedings, unless these examinations or this treatment otherwise qualifies as covered charges.
- Products purchased for nutrition purposes, including, but not limited to:
  - Megavitamin and nutrition-based therapy.
  - Nutritional counseling for either individuals or groups, including weight-loss programs, health clubs and spa programs, are excluded except in cases where the nutritional counseling is medically necessary, related to a condition covered by the plan, and performed by a registered dietician in individual sessions (benefits are limited to three sessions per lifetime for each medical condition). Some examples of medically necessary nutritional counseling are when the patient is diagnosed with diabetes mellitus, coronary artery disease, congestive heart failure, severe obstructive airway disease, gout, renal failure, phenylketonuria, and hyperlipidemias.
  - Enteral feedings and other nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, or oral minerals (however, these items may be covered if the formula or supplement is the sole source of nutrition or treats a specific inborn error of metabolism, is prescribed, and is not available over the counter).

- Medical supplies and appliances:
  - Devices used specifically as safety items or to affect performance in sports-related activities;
  - Prescribed or nonprescribed medical supplies and disposable supplies, including:
    - Elastic stockings.
    - Ace bandages.
    - Gauze and dressings.
    - Syringes and diabetic test strips (covered under Prescription Drug Program).
    - Orthotic appliances that straighten or reshape a body part (including some types of braces).
    - Tubings and masks, except when used with covered durable medical equipment.
  
- Foot care (except when needed for severe systemic disease):
  - Routine foot care (including the cutting or removal of corns and calluses), nail trimming, cutting or debriding.
  - Hygienic and preventive maintenance foot care, including cleaning and soaking the feet;
  - Applying skin creams in order to maintain skin tone.
  - Other services that are performed when there is not a localized illness, injury or symptom involving the foot.
  - Treatment of flat feet.
  - Treatment of subluxation of the foot.
  - Shoe orthotics.
  
- Treatment for mental health or substance abuse problems (covered under the Mental Health and Substance Abuse Plan).
  
- Charges for preventive services that are not medically necessary and are not considered covered preventive care under the plan.
  
- Charges you're not required to pay.
  
- Dental care, except care that's specifically covered under the plan.
  
- Any drugs, unless provided while confined in a hospital or unless they are injectable drugs that are routinely or customarily administered by a doctor or registered nurse (R.N.) in the provider's office.
  
- Any type of therapy, service or supply, including, but not limited to, spinal manipulations by a chiropractor or other doctor, for the treatment of a condition that ceases to be therapeutic treatment, as determined by the claims administrator, and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
  
- Nonrehabilitative educational care.
  
- Treatment or services that aren't prescribed as necessary by a doctor.



- Charges for which a claim for benefits isn't filed within six months (by June 30) following the year in which the covered charge is incurred.
- Transportation, other than the transportation services specifically provided by the plan.
- Sensitivity training or educational training therapy or treatment for an education requirement.
- Services provided while the recipient is covered under another health care plan to which Chevron contributes or has made contributions on your behalf.
- Treatment considered experimental, investigative or unproven because it does not meet generally accepted standards of medical practice in the U.S. This includes any related confinement, treatment, service or supply.
- Hospital charges for a private room in excess of the hospital's regular daily rate for semiprivate room accommodations.
- Services of a doctor who is in attendance but who is not providing face-to-face care or who is a standby surgeon to a surgical procedure (except as specifically covered under the plan).
- Services of a doctor's assistant.
- Skilled nursing facility charges for a private room in excess of the skilled nursing facility's regular daily rate for semiprivate room accommodations.
- Services and supplies in connection with an occupational injury or sickness. An occupational injury or sickness is an injury or sickness that is covered under a workers' compensation act or similar law. For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the workers' compensation act or similar law had that coverage been elected.
- Foreign language and sign language interpreters.
- Services that are self-directed to a free-standing or hospital-based diagnostic facility or ordered by a doctor affiliated with a diagnostic facility (hospital or free-standing) when that provider is not actively involved in your medical care. (This does not apply to mammography testing.)

# Health Care Review

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The plan includes Health Care Review procedures to help you get appropriate medical care in a cost effective setting. You or your provider must contact Personal Health Support at 1-800-654-0079 before you can qualify for full plan benefits for the following kinds of care:

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

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

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

When you notify UHC, it does *not* imply that the plan will pay full benefits or any benefits at all for a particular claim. Even though a provider prescribes treatments or services, UHC determines if the treatments or services are covered by the plan and are medically necessary.

If treatment is not considered medically necessary, the plan will not pay benefits. If you don't call within the required time period, benefits may be reduced to 60 percent of covered charges after the deductible, or may not be payable at all.

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

## **Inpatient Hospital Stay**

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

- Before you're hospitalized: Personal Health Support reviews your case with your doctor and advises on the anticipated number of days of hospitalization that may be needed.
- While you're hospitalized: Personal Health Support checks with your doctor to see how your treatment is progressing, and may arrange for additional care, such as visiting nurse services at home, or care in a rehabilitation center or skilled nursing facility.

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

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

## **Inpatient Childbirth (if stay exceeds federally mandated guidelines)**

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

You must call UHC for a length of stay in excess of these periods. If you don't notify Personal Health Support about an extended stay (prior to the extended stay), benefits for the additional days are reduced to 60 percent of covered charges, after the deductible.

## Reconstructive Surgery and Procedures

The plan can help pay for reconstructive surgery required to repair a birth defect or damage due to an accidental injury or disfiguring disease. To receive benefits for reconstructive surgery, you must notify Personal Health Support.

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

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

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

## Organ and Tissue Transplants

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

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

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

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

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

### **Transportation and Lodging**

Personal Health Support will assist the patient and family with travel and lodging arrangements. You or your network doctor must notify Personal Health Support before the time a pre-transplantation evaluation is performed at a transplant center. If you do not notify Personal Health Support, and if the services are not performed at a facility approved by UHC, benefits may be reduced to 60 percent of covered charges after you satisfy the deductible.

### **Rehabilitation (inpatient)**

If your doctor prescribes inpatient rehabilitation, you must notify Personal Health Support at least three business days before this care starts. If you don't make the call, benefits for inpatient rehabilitation may be reduced to 60 percent of covered charges after you satisfy the deductible.

### **Skilled Nursing Facility Care**

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

### **Private-Duty Nursing**

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

### **Home Health Care**

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

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

### **Home Infusion Therapy**

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

### **Hospice Care**

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

## **Durable Medical Equipment (if purchase or cumulative rental cost exceeds \$1,000)**

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

## **Accident Dental Services**

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

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

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

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

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

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

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

## Alternative Treatments

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

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

Alternative treatment determinations are made by UHC’s Personal Health Support and must be approved in advance.

## Appealing Health Care Review Decisions

If you contact UHC’s Personal Health Support for Health Care Review, and Personal Health Support determines that a treatment or test isn’t medically necessary or isn’t covered by the plan for other reasons, you and your provider can appeal this decision.

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

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

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

# Medical Claims and Appeals

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

## How to File a Medical Claim

If you go to a PPO network provider for care, your provider files the claim for you; otherwise, you have to file a claim as explained here. If you go to an out-of-network provider for care, you should file a medical claim as soon as you incur a covered charge, even if you haven't yet paid your deductible. Claim forms are available by clicking on "Forms" at [www.myuhc.com](http://www.myuhc.com) or by calling UnitedHealthcare at 1-800-654-0079. Claim forms also are available from the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.), or on the Benefits Connection website at [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree). When you receive services from an out-of-network provider, you are responsible for requesting payment from UnitedHealthcare. You must file the claim in a format that contains the following information:

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

The address of the claims administrator is:

UnitedHealthcare  
Chevron Group No. 247848  
P.O. Box 30555  
Salt Lake City, UT 84130-0555

You must file a claim for payment of plan benefits no later than six months (by June 30) following the calendar year in which the service was provided. If you don't file a proper claim with the claims administrator within this time frame, benefits for that health service will be denied. This time limit does not apply if you are legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends. If you provide written authorization to allow direct payment to a provider, all or a portion of any eligible covered charges due to a provider may be paid directly to the



provider instead of being paid to you. UnitedHealthcare will not reimburse third parties who have purchased or been assigned benefits by doctors or other providers. If your claim is denied, or if UnitedHealthcare needs more information before it can approve your claim, you'll be notified in writing. When a claim is denied, you can appeal the denial, as described further below. If your dispute concerns eligibility to participate in the plan, you must follow the procedures described in the How to File a Claim for Eligibility section in this summary plan description. **Note:** For information on how to file a prescription drug claim or a basic vision claim, please see the Medical PPO - Prescription Drug Program Coverage and the Medical PPO - Basic Vision Coverage sections.

## Initial Claim Review and Decision

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

### Types of Claims

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

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

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

### Time Limits for Processing Claims

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

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

<b>Time Limits for Processing Claims</b> <i>This chart describes the time limits for processing different types of claims.</i>			
Time Limits	Types of Claims		
	Urgent Care Health Claims	Preservice Health Claims	Postservice Health Claims
<b>Plan notice of failure to follow the proper claim procedures</b>	<b>Not later than 24 hours</b> after receiving the improper claim.	<b>Not later than 5 days</b> after receiving the improper claim.	<b>N/A</b>
<b>Your deadline to provide additional information required by the plan to decide your claim</b>	<b>48 hours</b> after receiving notice that additional information is required.	<b>45 days</b> after receiving notice that additional information is required.	<b>45 days</b> after receiving notice that additional information is required.
<b>Plan notice of initial claim decision</b>	<p>1. <b>Not later than 72 hours</b> after receiving the initial claim, if it was proper and complete.</p> <p>2. <b>Not later than 48 hours</b> after receiving additional information or after the expiration of your 48-hour deadline to provide such information to complete the claim, whichever is earlier</p>	<p>1. <b>Not later than 15 days</b> after receiving the initial claim, unless an extension, up to 15 days, is necessary due to matters beyond the control of the plan. The maximum time period is 30 days. You will be notified within the initial 15 days if an extension is needed.</p> <p>2. <b>Not later than 15 days</b> after receiving the initial claim, unless you need to provide additional information. You will be notified during the initial 15-day period and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving your additional information or after the expiration of your 45-day deadline to complete the claim, whichever is earlier.</p>	<p>1. <b>Not later than 30 days</b> after receiving the initial claim, unless an extension, up to 15 days, is necessary due to matters beyond the control of the plan. The maximum time period is 45 days. You will be notified within the initial 30 days if an extension is needed.</p> <p>2. <b>Not later than 30 days</b> after receiving the initial claim, unless you need to provide additional information. You will be notified during the initial 30-day period, and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving your additional information or after the expiration of your 45-day deadline to complete the claim, whichever is earlier.</p>

### **Concurrent Care Claims**

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

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

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

### **Notice and Payment of Claims**

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

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

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

## If Your Claim Is Denied

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

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

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

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

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

## How to File an Appeal

This section describes how to file an appeal with UHC and the time limits that apply to the different types of medical appeals.

<b>Time Limits for Processing Appeals</b>			
This chart describes the time limits for processing different types of appeals.			
Time Limits	Types of Claims		
	Urgent Care Health Claims	Preservice Health Claims	Postservice Health Claims
<b>Your deadline to file a first appeal</b>	<b>180 days</b> after receiving the claim denial notice.	<b>180 days</b> after receiving the claim denial notice.	<b>180 days</b> after receiving the claim denial notice.
<b>Plan notice of first appeal decision</b>	<b>Not later than 72 hours</b> after receiving an appeal.	<ol style="list-style-type: none"> <li><b>Not later than 15 days</b> after receiving an appeal, if the plan allows two levels of appeal.</li> <li><b>Not later than 30 days</b> after receiving an appeal, if the plan allows one level of appeal.</li> </ol>	<ol style="list-style-type: none"> <li><b>Not later than 30 days</b> after receiving an appeal, if the plan allows two levels of appeal.</li> <li><b>Not later than 60 days</b> after receiving an appeal, if the plan allows one level of appeal.</li> </ol>
<b>Your deadline to file a second appeal</b>	<b>N/A</b>	<b>90 days</b> after receiving the first appeal denial notice.	<b>90 days</b> after receiving the first appeal denial notice.
<b>Plan notice of second appeal decision</b>	<b>N/A</b>	<b>Not later than 15 days</b> after receiving a second appeal.	<b>Not later than 30 days</b> after receiving a second appeal.
<b>Your deadline to request an External Review</b>	<b>Four months</b> after receiving the appeal denial notice	<b>Four months</b> after receiving the second appeal denial notice	<b>Four months</b> after receiving the second appeal denial notice
<b>IRO notice of External Review Decision</b>	<b>Not later than 72 hours</b> after receiving the request for external review	<b>Not later than 45 days</b> after receiving the request for external review	<b>Not later than 45 days</b> after receiving the request for external review

## First Appeal

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

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

Your appeal should include *all* of the following:

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

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

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

### Where to Send Your First Appeal

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

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

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

### **Time Limits and Procedures for Processing Your First Appeal**

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

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

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

### **Notice of Decision on First Appeal**

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

If your first appeal is denied (in whole or in part), you will receive a written notice. The notice will contain information sufficient to identify the claim involved. The notice will state the reasons for the denial, including references to specific plan provisions upon which the denial was based and a statement of your right to file a civil lawsuit under Section 502(a) of ERISA following an adverse determination after completion of all levels of appeal/review required by the plan. The notice will state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

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

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

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

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

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

## **Second Appeal**

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

### **Time Limits and Procedures for Processing Your Second Appeal**

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

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



### **Notice of Decision on Second Appeal**

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

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

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

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

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

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

### **Requesting an External Review**

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

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

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

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

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

### **Expedited External Review**

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

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

To request an expedited external review, contact:

UnitedHealthcare

Phone: 1-800-654-0079

Fax: 1-813-818-3637

E-mail: [Plan Sponsor Appeal Services@uhc.com](mailto:Plan_Sponsor_Appeal_Services@uhc.com)

Mail: UnitedHealthcare

Attn Central Escalation Unit/Appeals | 601 Brooker Creek Rd | Oldsmar, FL 34677

## **Administrative Power and Responsibilities**

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

# If You're Covered by More Than One Health Plan

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

## How It Works

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

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

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

A plan other than your Medical PPO will be the primary payer if any of the following conditions applies to the other plan:

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

If your Medical PPO is the secondary payer, the combined benefit from both plans won't total more than your Medical PPO's limit for the covered charges. Here's an example of how this works.

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

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

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

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

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

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

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

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

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

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

## Coordinating with Medicare

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

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

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

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



# Basic Vision Coverage

## Chevron Medical PPO

VSP insures the basic vision benefits under the Medical PPO. You and your eligible dependents have basic vision coverage if you are enrolled in the Medical PPO.



# What the Plan Pays

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## Basic Vision through VSP Vision Care (VSP)

	Options 1, 2 and 3
Network	100% of the comprehensive eye exam, including dilation as needed, per calendar year.
Out-of-Network	Up to \$45 maximum reimbursement per calendar year for a comprehensive eye exam, including dilation as needed.

Discounts on eyeglasses, contact lenses and accessories are available from VSP network providers.

# Evidence of Coverage Document

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

- VSP at 1-800-877-7195.
- Go to [www.vsp.com/go/chevron](http://www.vsp.com/go/chevron) on the Internet.

## How to Use Your Basic Vision Benefit

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

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

## Basic Vision Claims

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

- VSP at 1-800-877-7195.
- Go to [www.vsp.com/go/chevron](http://www.vsp.com/go/chevron) on the Internet.

You must file a claim for payment of benefits no later than 365 days from the date the service was provided. If you don't file a proper claim with VSP within this timeframe, benefits for service will be denied. If your dispute concerns eligibility to participate in the plan, you must follow the procedures described in the How to File a Claim for Eligibility section in this book.



# Prescription Drugs

## Chevron Medical PPO

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

If you or a family member is eligible for Medicare and enrolled in the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, or the Chevron Senior Care Plan, you're **not** eligible for this program. Your prescription drug benefits are described in separate sections of this book.

## Overview

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- You and your eligible dependents are covered by the Chevron Prescription Drug Program if you are enrolled in the Medical PPO Plan.
- Express Scripts is the claims administrator of the Prescription Drug Program. Express Scripts has a network of retail pharmacies and a home delivery pharmacy program.
- You and your eligible dependents are covered by the Chevron Prescription Drug Program if enrolled in the Medical PPO.
- To help control pharmacy costs, the program encourages generic drug usage by charging more when the brand-name version of a drug is chosen over a generic version. If your doctor specifies that you receive a brand-name drug instead of a generic drug (by writing “Dispense as Written” on your prescription), or if you tell the pharmacist that you want a brand-name drug, even when a generic is available, your prescription will be filled with a brand-name drug. You’ll pay a \$5 generic copayment plus the difference between the cost of the brand-name drug and the generic drug unless your doctor provides the medical reason that neither the generic version of the drug, or other covered drugs that treat the same condition will work. In that case, you will not pay the difference between the cost of the brand-name drug and the generic drug.
- The Prescription Drug Program also features a list of preferred brand-name drugs designed to help keep costs down.

# Prescription Drug Benefit Overview

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

Program Feature	Retail Pharmacy (network)	Retail Pharmacy (out-of-network)	Home Delivery Service
<b>Deductible</b> (separate from medical deductible)	\$310 individual \$620 family	\$310 individual \$620 family	No deductible
<b>Annual Out-of-Pocket Maximum</b> (separate from medical plans' annual out-of-pocket maximum)	\$4,240 individual \$8,480 family	\$4,240 individual \$8,480 family	\$4,240 individual \$8,480 family
<b>Generic Drugs</b>	<b>After you pay the deductible, the plan pays:</b> 100% after \$5 copayment	<b>After you pay the deductible, the plan pays:</b> 100% of network price after \$5 copayment	<b>The plan pays:</b> 100% after \$15 copayment
<b>Preferred Brand-Name Drugs*</b>	80% You pay a \$15 minimum.	80% of network price You pay a \$ 15 minimum.	85% You pay a \$35 minimum.
<b>Nonpreferred Brand-Name Drugs*</b>	70% You pay a \$30 minimum.	70% of network price You pay a \$30 minimum.	75% You pay a \$75 minimum.
<b>Supply Limit***</b>	Up to a 30-day supply	Up to a 30-day supply	Up to a 90-day supply
<b>Refills Maintenance Drugs</b>	40% beginning with second refill of maintenance drug	40% of network price beginning with second refill of maintenance drug	Refills allowed
<b>Refills Specialty Maintenance Drugs</b>	Not covered	Not covered	Refills allowed

### \*Generic Drugs vs. Brand-Name Drugs

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

### \*\*Network Pharmacies vs. Out-of-Network Pharmacies

When you use a retail pharmacy that is out-of-network (or a network pharmacy is unable to verify your coverage) you pay your coinsurance percentage or copayment (depending on the type of drug prescribed) plus the difference between the network discounted price and the out-of-network price for your prescription.

\*\*\* If you are an Eligible Retiree covered by the Chevron Prescription Drug Plan and you reside permanently outside of the U.S., you and your covered dependents can fill prescriptions for up to a 365-day supply of covered maintenance medication at any Express Scripts network pharmacy or the Express Scripts mail-order pharmacy.



# Prescription Drug Deductible

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Your deductible is the amount of covered prescription drug charges for combined retail network and out-of-network benefits you pay each calendar year before the plan begins paying its share of those charges. The Prescription Drug Program deductible is separate from the deductible for the Medical PPO Plan.

Coverage Tier	Annual Deductible
You Only	\$310
You and Family (two or more)	\$620

Each covered individual has a maximum deductible equal to the “You Only” deductible amount. For example, if you choose the “You and Family” coverage tier, your annual deductible is satisfied when the family’s accumulation of deductibles reaches \$620, with no more than \$310 applied for each family member.

The following expenses don’t count toward the Prescription Drug Program deductible:

- Amounts you pay for prescriptions through the home delivery pharmacy program.
- The difference you pay between the cost of the brand-name drug and its generic equivalent unless your Doctor provides the medical reason that the generic version of the drug will not work.
- The difference between the network pharmacy price and the out-of-network pharmacy price if you use an out-of-network pharmacy (or you don’t provide your ID card at a network pharmacy).
- Charges for services or supplies that aren’t covered under the Prescription Drug Program.

# Prescription Drug Out-of-Pocket Maximum Feature

Under this feature, after your covered out-of-pocket costs reach the specified amount for the coverage tier, the Prescription Drug Program pays 100 percent of all covered charges until the end of the calendar year. The Prescription Drug Program out-of-pocket maximum is separate from the out-of-pocket maximum for the Medical PPO Plan.

Coverage Tier	Annual Out-of-Pocket Maximum
You Only	\$4,240
You and Family (two or more)	\$8,480

Each covered individual has an out-of-pocket amount equal to the “You Only” amount. For example, if you choose the “You and Family” coverage tier, your annual out-of-pocket maximum is satisfied when the family’s accumulation of out-of-pocket maximums reaches \$8,480, with no more than \$4,240 applied for each family member.

The following expenses don’t count toward the out-of-pocket maximum for prescription drugs, nor are they part of the 100 percent reimbursement after you reach your deductible/out-of-pocket maximums:

- Your deductible expenses.
- The difference you pay between the cost of the brand-name drug and its generic equivalent unless your Doctor provides the medical reason that the generic version of the drug will not work.
- The difference between the network pharmacy price and the out-of-network pharmacy price, if you use an out-of-network pharmacy (or you don’t provide your ID at a network pharmacy).
- The additional coinsurance amount you pay when you go to a retail network pharmacy after the first refill of a prescription for maintenance medication.
- Charges for services or supplies that aren’t covered under the Prescription Drug Program.

## Network Price

A discounted price charged for a prescription drug when a network pharmacy is used.

## Outpatient Prescription Drugs

Drugs that are dispensed by a retail or mail-order pharmacy (excluding drugs dispensed at hospitals, doctors’ offices or skilled nursing facilities).

**Generic Drug**

A chemical copy of a brand-name prescription drug. Generic medications contain the same active ingredients and must be equivalent in strength and dosage to their brand-name counterparts. They are subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength and purity as their brand-name counterparts. Generally, generic drugs cost less than brand-name drugs.

Some generics look different from the brand-name version of the drug because they contain different inactive ingredients. Inactive ingredients are, for example, additives that are used to keep a tablet from crumbling, to add bulk to a tablet, or to change a tablet's color or shape. Generic drugs typically cost 30 percent to 60 percent less than their brand-name counterparts because manufacturers of generic drugs don't have to pay for research and development or marketing and advertising.

**Brand-Name Drug**

A prescription drug that is *all* of the following:

- Manufactured and marketed under a trademark or a name given by a specific drug manufacturer.
- Typically protected under patent rights.
- Commonly acknowledged by pharmacies, drug companies and drug manufacturers as a brand-name drug.

**Preferred Brand-Name Drug**

Drugs that are covered by the Prescription Drug Program and receive a higher level of reimbursement compared with nonpreferred drugs. The list of preferred brand-name drugs (sometimes called a formulary list) includes commonly prescribed medications that have been selected based on their clinical effectiveness and on opportunities for savings. Preferred brand-name drugs receive a higher level of reimbursement compared with nonpreferred brand-name drugs. For updated formulary information, visit [www.Express-Scripts.com](http://www.Express-Scripts.com) or call Express Scripts Member Services at 1-800-987-8368.

**Nonpreferred Brand-Name Drug**

Drugs that are covered by the Prescription Drug Program, which receive a lower level of reimbursement compared with preferred brand-name drugs. These drugs are not on Express Scripts list of preferred brand-name drugs.

## Covered Medication

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

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

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

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

- Smoking deterrents (covered at 100%, with no deductible).
- Prescribed FDA approved female contraceptive methods including prescribed contraceptives which can be purchased over-the-counter (covered at 100%, with no deductible).
- Prescription vitamins (not over-the-counter), including prenatal vitamins.
- Retin-A, covered up to age 34.
- Needles, syringes and injectable medications.
- Fluoride Supplementations for dependents six months old through age 5 (covered at 100%, with no deductible).
- Doctor prescribed medications for preventive care as required by the Patient Protection and Affordable care Act with no deductible for certain generic over-the-counter drugs and generic prescription drugs. Examples of the medications are:
  - Aspirin to prevent cardiovascular events (men age 45 - 79, women age 55 - 79)

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

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

## **Prior Authorization**

The Prescription Drug Program covers some drugs only if they're prescribed for certain uses or only up to certain quantity levels. For this reason, some medications must be approved in advance before you can receive plan benefits. Drugs requiring prior authorization include:

- Growth hormones.
- Androgens.
- Drugs for multiple sclerosis such as Copaxone.
- Beta interferon drugs, such as Avonex and Betaseron.
- Erythroid/myeloid stimulants.
- Neumega.
- Central nervous system (CNS) stimulants such as Adderall, Concerta and Ritalin.
- Solodyn for treatment of acne.
- Anti-nausea drugs such as Anzemet, Casamet, Emend, Kytril and Zofran.
- Provigil.
- Forteo.
- Xolair.
- Retin-A, Avita, and Altinac creams after age 34.
- Interferons such as Actimmune and Pegasys.
- Immune globulin drugs.

- Xyrem for the treatment of narcolepsy.
- Specialty drugs for cancer therapy such as Avastin and Gleevec.
- Specialty drugs for the treatment of Respiratory Syncytial Virus such as Respigam and Synagis.
- Specialty drugs for rheumatoid arthritis or psoriasis such as Enbrel, Humira and Remicade.
- Xenazine, Cinryze, Arcalyst, and Solaris.
- Cox-II inhibitors, including Celebrex.
- Penlac.
- Lidoderm patches.
- Bronchodilators, including Spiriva.
- Anti-fungal agents, including Noxafil.
- Acthar Gel.
- Specialty pulmonary agents for treatment of cystic fibrosis, including Pulmozyme.
- Specialty drugs for the treatment of psoriasis, including Stelara.
- Specialty fertility agents, including Crinone and Procheive.
- Specialty drugs for the treatment of pulmonary arterial hypertension, including Adcirca, Letairis, Remodulin, Revatio, Tracleer, Tyvaso, and Ventavis.
- Specialty pulmonary agents, including Tobi and Crayston.
- Specialty drugs for the treatment of Hepatitis C, including Incivek and Victrelis.

A drug that is a type of drug listed above but is not specifically named above may be subject to the prior authorization requirements. For instance, Specialty drugs for cancer therapy other than Avastin and Gleevec may require prior authorization.

## Preferred Drug Step Therapy

To encourage the use of effective, lower-cost drugs, drugs in certain classes are covered only if preferred drugs, including generics, are used first (also referred to as “preferred drug step therapy”). Nonpreferred drugs are covered only if preauthorized by Express Scripts. Classes of drugs which require prior authorization under preferred drug step therapy are:

- Proton Pump Inhibitors including Aciphex, Prevacid, Protonix, Zegerid).
- Brand-name hypnotics (sleeping pills).
- Intranasal steroids including Nasacort, Rhinocort, Veramyst.
- Migraine drugs including Axert, Imitrex, Migranal NS, and Treximet.
- Osteoporosis drugs including Actonel and Fosomax D.
- Angiotensin II receptor blockers (ARBs) including Atacand, Avapro/Avalide, Benicar, Teveten, and Edarbi.
- Insulin Therapy drugs including Novolin.
- Ovulatory Stimulants including Gonal-F.
- Dermatologicals including Protopic and Elidel.
- Diabetic drugs including Jentadueto, Kazano, Nesina, Tradjenta.
- Glaucoma drugs including Rescula, Xalatan, Zioptan
- Respiratory, allergy, cough and cold inhaled Corticosteroids including Alvesco and Flovent

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

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

## **Medical Channel Management**

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

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

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

## **Home Delivery Requirement for Specialty Maintenance Drugs**

The second or later fill of a Specialty Drug that is a maintenance drug (as specified by Express Scripts) is covered after the first fill only if obtained from the Home Delivery Pharmacy Program.



## Drugs That Aren't Covered

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

- Non-federal legend drugs, including over-the-counter medications, unless otherwise specified in the Prescription Drug Program as covered.
- Anorexiant and appetite suppressants.
- Topical fluoride products except as required by the Patient Protection and Affordable Care Act.
- Retin-A, Avita and Altinac creams after age 34, unless prior authorization is obtained from Express Scripts.
- Blood glucose testing monitors (covered under the medical portion of the Medical PPO Plan).
- Therapeutic devices or appliances (including durable medical equipment).
- Drugs designed solely to promote or stimulate hair growth (including Rogaine and Propecia) or for cosmetic purposes only (such as Renova).
- Allergy serums (may be covered under the medical portion of the Medical PPO Plan).
- Immunization agents and vaccines.
- Biologicals and blood or blood plasma products.
- Drugs designated under federal law for investigational use or as experimental drugs, even if you're charged for the drugs.
- Refills in excess of the number prescribed by your doctor or dispensed more than one year after your doctor gave you the prescription.
- Drugs that are prescribed as part of your treatment while you are an inpatient in any facility, such as a hospital or skilled nursing facility that has a facility for dispensing drugs on its premises.
- Charges for the administration or injection of any drug.
- Refills of Specialty maintenance medications purchased at a retail pharmacy.
- Nonsedating antihistamines.

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

# Networks

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## When You Go to a Network Pharmacy

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

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

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

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

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

2. The pharmacist will process your prescription, using the program's computer system to confirm your eligibility and make sure the drug is covered under the plan. The computer system may notify the pharmacist if there's a potential problem with the prescription (such as a risk of adverse interaction with other drugs you're taking).
3. To encourage you to use the home delivery pharmacy services when you need maintenance medication, you will pay 60% percent of the cost if you go to a pharmacy for the second refill of a prescription for maintenance medication, with a \$5 minimum payment per generic drug and a \$15 minimum payment per preferred brand-name drug or a \$30 minimum for non-preferred brand name drug, up to the total cost of the drug. This plan provision doesn't apply to covered charges for smoking deterrents and fluoride supplements.

If you are an Eligible Retiree covered by the Chevron Prescription Drug Plan and you reside permanently outside of the U.S., you and your covered dependents can fill prescriptions for up to a 365-day supply of covered medication at any Express Scripts network pharmacy.

### **Network Pharmacy**

Express Scripts, the administrator of the Prescription Drug Program's retail pharmacy program, has negotiated a discount agreement with more than 60,000 pharmacies across the U.S. These pharmacies make up a network that includes pharmacy chains, pharmacies at discount stores, pharmacies at local and national grocery chains and many independent pharmacies. For participating pharmacies near you, visit [www.Express-Scripts.com](http://www.Express-Scripts.com) or call Express Scripts Member Services at 1-800-987-8368.

### **Prescription Drug Program ID Card**

When you enroll in the Medical PPO Plan, you'll receive a special prescription ID card to use every time you have a prescription filled at a network pharmacy. The card includes your member ID number, which is different from your medical plan ID number. (Note: Express Scripts did not issue new ID cards when they merged with Medco. You should continue to use your Medco ID card until a new one is issued to you.)

## **When You Go to a Pharmacy That's Out-of-Network**

If you go to a pharmacy that's out-of-network to fill prescriptions for up to a 30-day supply of covered medication, you'll pay the full price of the prescription and file a claim form.

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

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

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

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

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

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

## **Filing a Claim**

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

# Home Delivery Pharmacy Program

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

## Maintenance Medication

Medication taken over an extended period of time (90 days or more) for the treatment of a chronic condition, such as diabetes, arthritis, ulcers, high blood pressure or a heart condition.

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

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

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

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

If you are an Eligible Retiree covered by the Chevron Prescription Drug Plan and you reside permanently outside of the United States, you and your covered dependents can fill prescriptions for up to a 365-day supply of covered medication through the mail order pharmacy administered by Express Scripts. Allow a minimum of two to three weeks for new prescriptions.

## How to Order Medication by Mail

- Ask your doctor for a prescription for a 90-day supply of medication, with up to three refills. You can order a smaller supply, but you'll still pay the same minimum amount. If you need medication immediately, ask your doctor to write another prescription for a 14-day supply and have it filled at a pharmacy. If your doctor wants to try a new maintenance drug for a brief time, ask for two prescriptions — one for a small supply to monitor the drug's effectiveness and the second for a 90-day supply with refills. Take the first prescription to a network pharmacy to be filled. After you and your doctor determine that the new drug is effective, send the other prescription to the home delivery pharmacy.
- Your doctor can fax your prescriptions to Express Scripts. Ask your doctor to call 1-888-327-9791 for faxing instructions. Then call Express Scripts Member Services to make sure they have a valid telephone number and shipping address for you.
- If time permits, you can mail your prescriptions to Express Scripts. Please allow a minimum of two to three weeks for delivery. Call Express Scripts Member Services for the home delivery pharmacy address closest to where you want your medications mailed.
- Complete an order form and health assessment questionnaire (for your first order only), included in your information packet or available from Express Scripts Member Services at 1-800-987-8368. You can also request home delivery forms and envelopes by visiting [www.Express-Scripts.com](http://www.Express-Scripts.com).
- Check your doctor's prescription form to make sure it includes the correct dosage, your doctor's signature, and your name and address (or your covered dependent's name and address).
- Write your member ID number (found on your Prescription Drug Program ID card) on the back of the prescription slip.
- Use the envelope provided with your order form to send in the original prescription slip, your completed order form and your share of the cost of the drugs. Send your completed health assessment questionnaire in the separate envelope provided. Please allow up to 11 days for delivery. You can request express delivery at an additional cost.

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

## Ordering Prescription Refills by Mail

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

## Special Vacation Supply of Prescription Medication

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

- You can call Express Scripts Member Services at 1-800-987-8368 or log on to the website at [www.Express-Scripts.com](http://www.Express-Scripts.com) to find out how to arrange for an early refill of your medication. (Vacation supply requests are limited to two per 180 days.)
- You can call Express Scripts Member Services to get a list of network pharmacies in the areas you'll visit.
- You can order the medication you need ahead of time, using the program's home delivery pharmacy.
- You can go to an out-of-network pharmacy while you're on vacation and pay the entire cost and file a claim for reimbursement (the benefits under this option will be lower than if you use one of the other options).

# Prescription Drug Claims and Appeals

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

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

## How to File a Prescription Drug Claim

If your prescriptions are filled at a network pharmacy or through the program's home delivery pharmacy, you pay your share of the cost when you order the medication you need. There are no claim forms to fill out. However, if your prescription is filled at an out-of-network pharmacy or at a network pharmacy but your request is denied (for example, your ID card is rejected), you pay the full price charged for your medication and send in a completed claim form to request reimbursement of covered charges. You must file your claim form within one year after your prescription is filled. (Please note that this is different from the time period to file claims under the Medical PPO.) Otherwise, no benefits will be payable for that prescription. If you don't file a proper claim with Express Scripts within this time frame, benefits will be denied.

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

- Date prescription was filled.
- Name and address of the pharmacy.
- National Drug Code (NDC) number.
- Name of drug and strength.
- Quantity.
- Prescription (Rx) number.
- "Dispense as Written," if applicable.
- Amount paid for the medication.



Mail the completed claim form to the address shown on the form.

If your claim is denied (in whole or in part), or if Express Scripts needs more information before it can approve your claim, you'll be notified in writing. When a claim is denied, you can appeal the denial as described below. If your dispute concerns eligibility to participate in the plan, you must follow the procedures described in the How to File a Claim for Eligibility section in this book. **Note:** For information on how to file a medical benefit claim or a basic vision claim, please see the Medical PPO - Medical Coverage and Medical PPO - Basic Vision Coverage sections.

## Initial Review and Decision

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

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

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

### Urgent Care Claims

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

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

### **Claims for Other Prescription Drug Benefits**

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

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

Your claim will be processed within the time limits set forth in the chart, *Time Limits for Processing Prescription Drug Appeals*. If your claim is approved, benefits will be paid to the pharmacy unless you have already paid for the prescription drug, in which case benefits will be payable to you. When a written claim is denied, you can appeal the denial.

### **If Your Prescription Drug Claim Is Denied**

If your prescription drug claim is denied (in whole or in part), you will receive a written notice from Express Scripts that includes *all* of the following:

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

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

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

## How to File an Appeal

This section describes how to file an appeal with Express Scripts and the time limits that apply to the different types of prescription drug appeals.

<b>Time Limits for Processing Prescription Drug Appeals</b>			
This chart describes time limits for processing different types of prescription drug appeals.			
Time Limits	Types of Claims		
	Urgent Care Prescription Drug Claims	All Other Prescription Drug Claims (except member-submitted paper claims)	Member-Submitted Paper Claims for Prescription Drugs
<b>Your deadline to file a first appeal</b>	<b>180 days</b> after receiving the claim denial notice.	<b>180 days</b> after receiving the claim denial notice.	<b>180 days</b> after receiving the claim denial notice.
<b>Plan notice of first appeal decision</b>	<b>Not later than 72 hours</b> after receiving an appeal.	<b>Not later than 15 days</b> after receiving an appeal.	<b>Not later than 30 days</b> after receiving an appeal.
<b>Your deadline to file a second appeal</b>	N/A	<b>90 days</b> after receiving the first appeal denial notice.	<b>90 days</b> after receiving the first appeal denial notice.
<b>Plan notice of second appeal decision</b>	N/A	<b>Not later than 15 days</b> after receiving a second appeal.	<b>Not later than 30 days</b> after receiving a second appeal.
<b>Your deadline to request an External Review</b>	<b>Four months</b> after receiving the appeal denial notice	<b>Four months</b> after receiving the second appeal denial notice	<b>Four months</b> after receiving the second appeal denial notice
<b>IRO notice of External Review Decision</b>	<b>Not later than 72 hours</b> after receiving the request for external review	<b>Not later than 45 days</b> after receiving the request for external review	<b>Not later than 45 days</b> after receiving the request for external review

## How to File an Appeal: First Appeal

After receiving the notice of denial, you or your authorized representative (this can be your provider, your beneficiary, your legal representative or another appropriately authorized individual) may ask for an appeal, which is a full and fair review of the initial claim decision, by writing to Express Scripts. Your first appeal must be submitted in writing within 180 days after the claim is denied.

During the time limit for requesting a first appeal, you or your authorized representative will be given reasonable access to all documents and information (other than legally or medically privileged documents) relevant to the claim, and you may request copies free of charge. You may also request to review the claim file. You also can submit written comments, documents, records and other information pertinent to your claim to Express Scripts.

Your written first appeal should include the following information:

- Your full name even if the claim is for your dependent.
- Your member ID number located on your Express Scripts ID card.
- Your phone number.
- The prescription drug for which coverage has been denied.
- An explanation of why you believe the prescription drug should be covered.
- Any supporting information or documentation.

For a prescription drug claim only, send your written request for a first appeal to:

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

If your urgent care claim is denied, you have the right to request an urgent appeal of the adverse determination. Urgent appeal requests may be oral or written. You or your doctor can call 1-800-987-8368 or send a written appeal request to the above address. In the case of an appeal for coverage involving an urgent care claim, you will be notified of the benefit determination within 72 hours of receipt of the appeal. This coverage decision is final and binding. There is only one level of internal appeal for an urgent care claim, but you may request an expedited external review of a denial of an appeal involving urgent care.

### Time Limits and Procedures for Processing Your First Appeal

Upon receipt of your first appeal, Express Scripts will review the claim again and make a decision based on all comments, documents, records and other information you've submitted, without regard to whether such information was submitted or considered in the initial benefit determination. Express Scripts will make its determination on your first appeal in accordance with the time limits shown in the chart, *Time Limits for Processing Prescription Drug Appeals*. The review on appeal will not afford deference to the initial denial, and it will be conducted by a fiduciary who is neither the individual who initially denied the claim that is the subject of the appeal nor the subordinate of such individual.

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

#### **Notice of Decision on First Appeal**

If, on first appeal, Express Scripts determines that your explanation and additional information support the payment of your claim, Express Scripts will process your prescription and benefits will be paid to the pharmacy, unless you have already paid for the prescription drug, in which case benefits will be payable to you.

If your first appeal is denied (in whole or in part), you will receive a written notice. The notice will contain information sufficient to identify the claim involved. The notice will state the reasons for the denial, including references to specific plan provisions upon which the denial was based and a statement of your right to file a civil lawsuit under Section 502(a) of ERISA following an adverse determination after completion of all levels of appeal/review required by the plan. The notice will state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

If, on first appeal, Express Scripts upholds the denial of your claim, you may file a second appeal within 90 days after receiving the notice of denial of your first appeal. However, there is only one level of internal appeal for an urgent care claim.

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

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

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

Express Scripts is the named fiduciary that serves as the committee and, in its sole discretion, has the authority to interpret plan provisions, as well as facts and other information related to claims for which a first appeal is requested.

## How to File an Appeal: Second Appeal

After receiving the notice of denial of your first appeal, you or your authorized representative (this can be your provider, your beneficiary, your legal representative or another appropriately authorized individual) may ask for a second appeal.

During the time limit for requesting a second appeal, you or your authorized representative will be given reasonable access to all documents and information (other than legally or medically privileged documents) relevant to the claim, and you may request copies free of charge. You may also request to review the claim file. You also can submit written comments, documents, records and other information or testimony pertinent to your claim to Express Scripts.

Your second appeal must be submitted in writing within 90 days after your first appeal is denied. Your written second appeal should include the following information:

- Your full name even if the claim is for your dependent.
- Your member ID number located on your Express Scripts ID card.
- Your phone number.
- The prescription drug for which coverage has been denied.
- An explanation of why you believe the prescription drug should be covered.
- Any supporting information or documentation.

The second appeal should also include any additional information that wasn't previously submitted with your first appeal, as well as an explanation supporting your position.

For a prescription drug claim only, send your written request for a second appeal to:

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

### Time Limits and Procedures for Processing Your Second Appeal

Upon receipt of your second appeal, Express Scripts will review the claim again and make a decision based on all comments, documents, records and other information you've submitted, without regard to whether such information was submitted or considered in the initial benefit determination. Express Scripts will make its determination on your second appeal in accordance with the time limits shown in the chart, *Time Limits for Processing Appeals*, in this section.

The review on second appeal will not afford deference to the initial denial, and it will be conducted by a fiduciary who is neither the individual who denied the claim or first appeal nor the subordinate of such individuals.

The second appeal will follow the same procedural steps as described for the first appeal.

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

#### **Notice of Decision on Second Appeal**

If, on second appeal, Express Scripts determines that your explanation and additional information support the payment of your claim, Express Scripts will process your prescription and benefits will be paid to the pharmacy, unless you have already paid for the prescription drug, in which case benefits will be payable to you.

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

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

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

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

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

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

## Requesting an External Review

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

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

You or your authorized representative can request an external review in writing or verbally to Express Scripts by following instructions in your denial letter or contacting Express Scripts at:

Attn: External Review Requests  
Express Scripts  
P.O. Box 631850  
Irving, TX 75063-0030

1-800-743-2851  
1-888-235-8551 (fax)

You must request the external review within four months after the date of receipt of a denial of your second appeal. Express Scripts will provide an external review procedure through an accredited Independent Review Organization (IRO) after determining the following:

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

Within one business day of completing the preliminary review, Express Scripts will notify you in writing of the name and contact information for the IRO reviewing your request for external review. The notice will include a statement that you may submit in writing to the IRO within 10 business days any additional information that you want the IRO to consider when conducting the external review. Within five business days after the date of assignment to the IRO, Express Scripts will provide to the IRO the documents and any information considered in making the adverse benefit determination, and the terms of the Prescription Drug Program.

The IRO will conduct an external review of an adverse benefit determination and issue a final external review decision. The IRO will communicate their external review decision to you and to Express Scripts. If the IRO determines that your explanation and additional information support the payment of your claim, Express Scripts will immediately provide coverage or payment of the claim. If your external review is denied, you will receive a written notice from the IRO within 45 days.



### **Expedited External Review**

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

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

To request an expedited external review, contact Express Scripts:

Phone: 1-800-743-2851

Fax: 1-888-235-8551

Mail: Express Scripts

Attn: External Review Requests | P.O. Box 631850 | Irving, TX 75063-0030

### **Administrative Power and Responsibilities**

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

# If You're Covered by More Than Prescription Drug Program

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Coordination of benefits is a feature used to determine how much the Prescription Drug Program pays when you or one of your dependents is covered by more than one group prescription drug plan and incur covered charges for prescription drugs. This feature is designed to prevent overpayment of benefits. This section does not apply to medical coverage or the basic vision coverage under the Medical PPO.

## How It Works

Under the coordination of benefits rules, one plan pays benefits first (the *primary payer*) and one plan pays second (the *secondary payer*). The primary payer pays the benefits provided by its plan features. The secondary payer then pays any excess amounts required to bring the total benefits paid up to the levels payable under its plan. The sum of the benefits paid from each plan will not exceed the actual expense incurred.

## Coordination of Benefits Under the Prescription Drug Program

If you or one of your dependents is covered by more than one group medical plan when you use the home delivery pharmacy or when you present your Prescription Drug Program ID card at a network retail pharmacy, Express Scripts will cover the drug as if it is the primary payer, regardless of which plan is primary, and you don't have to submit a claim form. However, if you or one of your dependents is covered by more than one health care plan and does not utilize the home delivery pharmacy or present a Prescription Drug Program ID Card at a retail pharmacy then this Prescription Drug Program is the secondary plan, or if you want the Prescription Drug Program to be the secondary payer, you must submit a claim form, along with the documentation requested on the form to Express Scripts. Be sure to indicate that you are requesting reimbursement under the coordination of benefits feature.

In this case, provided you or your dependent, as applicable, has met the deductible requirement under this Prescription Drug Program, if allowable medical expenses exceed the amount covered by all primary plans, the benefit under this Prescription Drug Program will be the lesser of the amount submitted or what the primary plan(s) did not pay for the prescription drug, up to the maximum amount this Prescription Drug Program would have paid if this Prescription Drug Program were the primary plan. Any Prescription Drug Program co-insurance requirements also apply. Under no circumstances will the sum of the benefits paid from each plan exceed the actual expense incurred.

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

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

A plan other than your Medical PPO will be the primary payer if any of the following conditions applies to the other plan:

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

If your Medical PPO is the secondary payer, the combined benefit from both plans won't total more than your Medical PPO's limit for the covered charges. Here's an example of how this works.

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

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

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

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

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

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

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

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

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

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



# Chevron Medicare Plus Plan

This section describes the Medicare Plus Plan that Chevron offers to Medicare-eligible retirees. The plan covers a broad range of medical services when combined with benefits provided by federal Medicare. The plan includes prescription drug coverage under the Express Scripts Medicare™ (PDP), a Medicare-approved prescription drug plan administered by Express Scripts®. The plan also includes a Vision Program administered by VSP.

**Note:** Medicare-eligible retirees also have the option of choosing the Chevron Medicare Standard Plan or the Chevron Senior Care Plan (described in later sections) or a Medicare HMO offered by the company (if available in your area). **The Chevron Medicare Plus Plan is not available to Unocal retirees who retired before July 1, 2006, or to their survivors.**

- Medical Coverage – UnitedHealthcare (UHC)
- Basic Vision Coverage - VSP Vision Care (VSP)
- Prescription Drugs - Express Scripts

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**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.**



# Medical Coverage

## Chevron Medicare Plus Plan

The Chevron Medicare Plus Plan, hereafter referred to as the Medicare Plus Plan, is administered by UnitedHealthcare.

Depending on where you live, you may be eligible for a medical health maintenance organization (HMO) plan. If you choose an HMO for your medical coverage, you'll want to review the Medical and Dental HMO Supplement section.



# Overview of Benefits

This outline is intended to provide you with an overview of the benefits available under the plan and is not intended to be all-inclusive. Please refer to each applicable section for more detailed information about these benefits. Important terms used below are defined later under How the Plan Works; they are important for determining the benefits available under the plan.

Service or Supply	What the Plan Pays
<b>Medicare Part A and Part B deductibles</b>	80% of covered charges in excess of federal Medicare payments; the 20% you pay counts toward your annual Chevron Medicare Plus Plan deductible/out-of-pocket maximum
<b>Inpatient hospitalization</b> <ul style="list-style-type: none"> <li>• Room and board at semiprivate room rate</li> <li>• Hospital-related expenses, including operating room, X-rays and lab tests.</li> </ul>	80% of covered charges in excess of federal Medicare payments after you pay the annual deductible; 100% of covered charges after \$1,500 deductible/out-of-pocket maximum per person is reached
<b>Other medical services:</b> <ul style="list-style-type: none"> <li>• Blood</li> <li>• Skilled nursing care (for the 21st through 100th day of confinement)</li> <li>• Ambulatory surgical center services</li> <li>• Medical supplies and equipment</li> <li>• Doctors' and therapists' care provided in a doctor's office, a hospital, or an outpatient facility</li> <li>• Cardiac rehabilitation therapy</li> <li>• Home health care</li> <li>• Hospice care</li> <li>• Certain nursing care services (\$10,000 maximum benefit per plan member per year). To receive benefits, patient must notify UnitedHealthcare's Personal Health Support</li> <li>• Ambulance transportation</li> <li>• Certain kinds of reconstructive cosmetic surgery</li> <li>• Dental care, if teeth are damaged or lost due to accidental injury, other than a chewing injury</li> <li>• Mental health care — inpatient treatment and outpatient visits</li> <li>• Substance abuse treatment — inpatient hospital care covered; certain types of outpatient treatment covered as well</li> <li>• Inpatient and outpatient prescription drugs that are covered under Medicare Part B</li> <li>• Diabetic testing supplies</li> <li>• Prescription drugs filled on an emergency basis while traveling outside the U.S.</li> </ul>	80% of covered charges in excess of federal Medicare payments after you pay the annual deductible; 100% of covered charges after \$1,500 deductible/out-of-pocket maximum per person is reached
<b>Second and third surgical opinions</b>	100% of covered charges in excess of federal Medicare payments
<b>Vision care</b>	For details, refer to the Vision Program section
<b>Prescription drugs</b>	For details, refer to the Prescription Drug section

## How Much You Pay for Coverage

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If you enroll in this plan, you and Chevron currently share the cost of coverage. Your monthly contribution also depends on the number of dependents you enroll. Current rates are available from the HR Service Center. (See Appendix: Company Contributions for Retiree Health Care Coverage for more details about your coverage cost. In the Eligibility and Participation section, see Paying for Coverage for an explanation of how you pay your share of the cost of coverage.)

## How the Plan Works

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The Chevron Medicare Plus Plan pays a portion of covered charges (defined below) in excess of amounts Medicare pays for certain services. Therefore, if you or your covered dependents are eligible for Medicare, you should enroll in both Part A and Part B, because benefits under the Chevron Medicare Plus Plan will be calculated as though you are covered under Medicare Part A and Part B.

In addition, the plan covers a few services that are not covered by federal Medicare. (See When Charges Are Covered Only by the Medicare Plus Plan for an explanation of how benefits are calculated when care is covered only under the Chevron Medicare Plus Plan — and not by federal Medicare.)

### **Covered Charges**

The amount of any benefit paid under this plan is determined based on the charges recognized by the plan. These recognized charges are called *covered charges*.

With the exception of prescription drugs and the Vision Program benefits, covered charges under the plan will either be the Medicare-approved amount (defined below) or the allowable charge (defined later in this section), depending on the situation.

Covered charges for the services and supplies covered by this plan and also covered by Medicare always will be based on the Medicare-approved amount. A service or supply covered under this plan must be used for the treatment of a nonoccupational sickness or injury provided under the care or direction of a doctor.

**When the provider accepts Medicare assignment** of benefits, covered charges for any benefits payable under the Medicare Plus Plan, if any, will be based on the actual Medicare-approved amount.

**When the provider does not accept Medicare assignment** of benefits, covered charges for benefits payable under the Medicare Plus Plan, if any, will be based on the maximum amount Medicare permits providers to charge for covered services, currently 115 percent of the Medicare-approved amount.

Covered charges for all other services and supplies that are covered under the Chevron Medicare Plus Plan and not covered by Medicare, like home oxygen use, will always be based on the allowable charge.

**Incurred Expenses**

Covered medical expenses that you or your dependents incur will be considered under this plan, provided coverage is in effect on the date you or your dependents incur the medical expense. Covered medical expenses are considered incurred on the date the service is rendered or the date the product or supply is furnished.

The plan covers only services or supplies that are considered medically necessary (as defined below) for the diagnosis, treatment or care of a sickness or injury. If the following services and supplies meet this requirement, they are covered by the Chevron Medicare Plus Plan, even if denied by Medicare:

- Surgical stockings.
- Cardiac rehabilitation.
- Home oxygen.
- Glucometer.
- Diabetes supplies (excludes syringes, needles and insulin, which are covered under the Express Scripts Medicare™ (PDP)).
- IV therapy and IV home infusion.
- Orthopedic equipment and devices that are custom made.

The plan doesn't pay for certain services, as explained under the Expenses That Aren't Covered Under the Chevron Medicare Plus Plan section.

### **Medically Necessary**

This term generally refers to health care services and supplies that are determined by the claims administrator, in its sole discretion, to be medically appropriate and that are all of the following:

- Necessary to meet the basic health needs of the plan member or covered dependent.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the health care service or supply.
- Consistent in type, frequency and duration with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the claims administrator as to the type, frequency and duration of treatment.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the comfort or convenience of the patient, the patient's family, the doctor or other provider.
- Demonstrated through prevailing peer-reviewed medical literature to be either of the following:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed.
  - Safe, with promising efficacy for treating a life-threatening sickness or condition, provided in a clinically controlled research setting, and using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

For purposes of this definition, the term “life-threatening” is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment. The fact that a doctor has performed, prescribed, ordered, recommended or approved a procedure or treatment, or the fact that it may be the only treatment for a particular illness, injury or pregnancy doesn't mean that it's medically necessary and appropriate as defined above.

### **Therapeutic vs. Maintenance Care**

There may come a time in treatment — for example, in the case of chiropractic care and speech, physical, orthoptic and occupational therapies — when the care provided ceases to be “therapeutic” and instead is administered to “maintain” a level of functioning. Maintenance care does not satisfy the Chevron Medicare Standard Plan's definition of a covered health service and, therefore, is not covered under the plan.

# Deductibles

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Your deductible is the amount of covered health care charges you pay each calendar year before the plan begins paying its share of those charges.

- The annual medical expense deductible is \$300 for each covered person.
- This deductible is in addition to the Medicare deductible and the separate Express Scripts Medicare™ (PDP) deductible.
- After you pay your deductible, the plan pays a percentage of covered charges for the care you need, and you pay any costs above the amount paid by the plan.

## Expenses That Don't Count Toward the Deductible

Your deductible expenses don't count toward the out-of-pocket maximum amount, and the following expenses don't count toward your deductibles:

- Charges in excess of covered charges.
- Charges for services or supplies that aren't medically necessary.
- Charges for services or supplies that aren't covered under the plan.
- Your share of the cost of medication purchased through the Express Scripts Medicare™ (PDP).
- Your share of the cost for eyewear, exams, or other vision products purchased through the plan's Vision Program.
- Expenses you pay because you didn't get advance approval for private-duty nursing.
- Expenses you pay because you didn't get advance approval for substance abuse treatment.

# Annual Out-of-Pocket Maximum

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Under the out-of-pocket maximum feature for medical plan expenses, after your out-of-pocket costs reach \$1,500 for each covered person, the plan pays 100 percent of all covered charges until the end of the calendar year. Charges covered under the Express Scripts Medicare™ (PDP) and the Vision Program do not count toward your out-of-pocket maximum. (Keep in mind the Express Scripts Medicare™ (PDP) has a separate annual out-of-pocket limit for each covered person.)

## Expenses That Don't Count Toward the Out-of-Pocket Maximum Amount

Your deductible expenses don't count toward the out-of-pocket maximum amount, and the following expenses don't count toward the out-of-pocket maximum amount:

- Charges in excess of covered charges.
- Charges for services or supplies that aren't medically necessary.
- Charges for services or supplies that aren't covered under the plan.
- Your share of the cost of medication purchased through the Express Scripts Medicare™ (PDP).
- Your share of the cost for eyewear, exams, or other vision products purchased through the plan's Vision Program.
- Expenses you pay because you didn't get advance approval for private-duty nursing.
- Expenses you pay because you didn't get advance approval for substance abuse treatment.

# When Charges Are Covered by Both Federal Medicare and the Chevron Medicare Plus Plan

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When charges for health care are covered by both federal Medicare and the Chevron Medicare Plus Plan, benefits under the Chevron Medicare Plus Plan are based on Medicare-approved charges. The method for determining benefits depends on whether your health care provider accepts Medicare's "assignment" of approved charges.

When health care providers accept assignment, they agree to accept Medicare's guidelines of the approved charge for the services rendered (even if Medicare's approved charge is less than the actual charge).

When providers don't accept Medicare's approved charge for their services, there's a federal limit on the amount they can receive for their services. Under current law, the maximum amount they can receive is 115 percent of Medicare's approved charge.

## Medicare-Approved Amount (or Medicare-Approved Charge)

The Medicare-approved amount or charge is the charge on which Medicare bases its payment. In most cases, Medicare's approved amount will be less than the allowable charge.

## When Your Health Care Provider Accepts Assignment

When your health care provider accepts assignment, the Medicare-approved amount is the maximum "covered charge" under the Chevron Medicare Plus Plan. The Chevron Medicare Plus Plan pays 80 percent of the portion of the covered charge that remains after Medicare's payment. Here's an example:

Assume that a doctor's usual charge for a service is \$220 and the Medicare-approved amount for the service is \$200. Medicare pays 80 percent of the approved amount (after Medicare deductibles have been paid), or \$160 ( $\$200 \times 80\% = \$160$ ).

Here's how to calculate the Chevron Medicare Plus Plan benefit:

- **Step 1.** Subtract Medicare's payment from the Medicare-approved amount to determine the covered charge under the Chevron Medicare Plus Plan ( $\$200 - \$160 = \$40$ ).
- **Step 2.** Calculate the Chevron Medicare Plus Plan's benefit by multiplying the result of Step 1 by 80 percent ( $\$40 \times 80\% = \$32$ ).
- **Step 3.** Calculate your share of the cost by multiplying the result of Step 1 by 20 percent ( $\$40 \times 20\% = \$8$ ).

In this example, Medicare pays \$160, the Chevron Medicare Plus Plan pays \$32, and you pay \$8, for a total of \$200 (the covered charge under the Chevron Medicare Plus Plan).



## When Your Health Care Provider Doesn't Accept Medicare Assignment

When your health care provider doesn't accept Medicare assignment, benefits under the Chevron Medicare Plus Plan are usually based on the federal limit on what providers can be paid for their services — 115 percent of the Medicare-approved amount (or the actual charge, if less). The Chevron Medicare Plus Plan pays 80 percent of the covered charge that remains after Medicare's payment. Here's an example:

Assume that a doctor's actual charge for a service is \$220, that the Medicare-approved amount is \$200, and that Medicare pays 80 percent of this amount, or \$160 ( $\$200 \times 80\% = \$160$ ), after deductibles have been met.

Here's how to calculate the Chevron Medicare Plus Plan benefit:

- **Step 1.** Determine the "covered charge" under the Chevron Medicare Plus Plan as follows:
  - a. Multiply the Medicare-approved charge by 115 percent ( $\$200 \times 115\% = \$230$ ).
  - b. The lower amount — the result of 1a. or the doctor's actual charge — is the covered charge under the Chevron Medicare Plus Plan. (In this case, the lower amount is the doctor's actual charge of \$220).
- **Step 2.** Subtract Medicare's payment from the covered charge under the Chevron Medicare Plus Plan ( $\$220 - \$160 = \$60$ ).
- **Step 3.** Calculate the Chevron Medicare Plus Plan's benefit by multiplying the result of Step 2 by 80 percent ( $\$60 \times 80\% = \$48$ ).
- **Step 4.** Calculate your share of the cost by multiplying the result of Step 2 by 20 percent ( $\$60 \times 20\% = \$12$ ).

In this example, Medicare pays \$160, the Chevron Medicare Plus Plan pays \$48, and you pay \$12, for a total of \$220 (the covered charge under the Chevron Medicare Plus Plan).

## When Charges Are Covered Only by the Medicare Plus Plan

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When charges are covered by the Chevron Medicare Plus Plan — but not by federal Medicare — the plan’s “allowable charge” limits apply. The plan’s claims administrator determines whether a charge is allowable, as explained below. If a charge is more than the allowable amount, the excess charges are not covered under the plan.

### **Allowable Charge**

Allowable charge means an amount measured and determined by the claims administrator by comparing the actual charge for a service or supply with the prevailing charges made for it. The claims administrator, in its sole discretion, determines the prevailing charge, taking into account pertinent factors including, but not limited to:

- The Medicare-approved amount for such service.
- The complexity of the service.
- The range of services provided.
- The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

Allowable charges for prescription drug and vision claims will be determined separately (if applicable) by the claims administrators of the Express Scripts Medicare™ (PDP) and the Vision Program.

### **Predetermination of Benefits**

If you’re uncertain whether a service will be covered by the plan, in advance of treatment you or your doctor should contact UnitedHealthcare at 1-800-654-0079. A representative will let you know what services are covered.

## Covered Health Care Services

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In general, the plan pays 80 percent of deductibles required under both Part A (hospitalization) and Part B (doctors' services) of Medicare.

In addition, for the following medical services and treatment, after you pay the annual deductible, the plan pays 80 percent of covered charges that remain after Medicare's payment.

### Hospital Room and Board, Services and Supplies

After you pay the annual deductible, the plan pays 80 percent of covered room and board charges (excluding additional charges for personal items such as telephones, radios and televisions) that remain after Medicare's payment — up to the hospital's average semiprivate rate. If you're admitted to a private room, plan benefits will still be based on the portion of the hospital's average semiprivate room and board charge that remains after Medicare's payment. After you pay the annual deductible, the plan also pays 80 percent of covered charges that remain after Medicare's payment for the following hospital services and supplies related to a hospital stay:

- Operating room.
- X-rays and lab tests.
- Drugs, injections, oxygen, anesthesia supplies, blood and blood plasma (if not donated or replaced), and charges associated with providing these supplies.
- Intensive care unit, cardiac care unit, and isolation room charges in excess of the semiprivate room rate.
- Outpatient hospital charges, including charges for emergency room care.

## **Hospital**

A hospital must meet one of the following requirements:

- A legally constituted and operated institution having, on its premises, organized facilities (including diagnostic and major surgical facilities) for the care and treatment of sick and injured people. Care must be supervised by a staff of legally qualified doctors, and there must be a registered nurse (R.N.) on duty at all times.
- A free-standing rehabilitative facility that meets all of the following criteria:
  - Has a provider agreement, as required by Medicare.
  - Serves an inpatient population, with at least 75 percent of patients needing intensive rehabilitative services for the treatment of a stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of the femur, brain injury, polyarthritis, neurological disorders and burns.
  - Has a preadmission screening procedure to determine whether the patient would benefit from an intensive inpatient hospital program.
  - Ensures that patients receive close medical supervision and furnishes rehabilitation nursing, physical therapy and occupational therapy by qualified personnel.
  - Has a director of rehabilitation who is a doctor.
  - Establishes a plan of treatment for every patient that is reviewed as needed by a doctor who consults with other qualified personnel.
  - Uses a coordinated team approach to rehabilitate each patient.

The term “hospital” doesn’t include any of the following facilities:

- Any institution used primarily as a rest or nursing facility.
- Any facility solely for use by the aged or the chronically ill or by convalescents, drug addicts or alcoholics.
- Any facility providing primarily educational or custodial care (defined under Nursing Care Services in this section).

## **Inpatient Childbirth**

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).

## Skilled Nursing Facility Care

Skilled nursing facilities offer an alternative to hospitals as a place where you can recuperate. After you pay the annual deductible, the plan pays 80 percent of Medicare-approved charges not paid by Medicare for days 21–100 in each benefit period. Medicare pays for the first 20 days. The Chevron Medicare Plus Plan does not cover the first 20 days of care in a skilled nursing facility, or care beyond 100 days.

Covered charges in a skilled nursing facility include:

- Semiprivate room.
- Skilled nursing care.
- Medical supplies and equipment.
- Prescribed drugs and biologicals.

Charges can be covered if all of the following conditions are met:

- A doctor prescribes confinement to this type of facility.
- The facility is a Medicare provider, the services are covered by Medicare, and the services are provided in a bed designated by the facility as a Medicare bed.
- The patient would have to be confined to a hospital if the skilled nursing facility services weren't used.

You or your doctor should check with UnitedHealthcare or Medicare to make sure the facility you select qualifies as a skilled nursing facility and is a Medicare-approved provider. Custodial care in a skilled nursing facility isn't covered, even if a doctor recommends it.

### Skilled Nursing Facility

An institution that charges a fee and meets *all* of the following requirements:

- It furnishes room and board and nursing services for medical care.
- It has one or more licensed nurses on duty at all times, working under the constant supervision of a registered nurse (R.N.) or licensed doctor.
- It has available, at all times, the services of a licensed doctor.
- It complies with all legal requirements applicable to the operation of such an institution.
- It maintains medical records on all its patients at all times.
- It's approved under Medicare.

The term "skilled nursing facility" doesn't include any of the following:

- An institution used primarily as a rest facility.
- Facilities for the aged, for drug addicts, or for alcoholics.
- Facilities provided primarily for custodial or educational care.

## **Ambulatory Surgical Center Services**

After you pay the annual deductible, the plan pays 80 percent of the portion of covered charges that remains after Medicare's payment for outpatient surgery for:

- Use of an operating room.
- Diagnostic X-rays and lab tests.
- Oxygen.
- Anesthesia supplies.
- Blood and blood plasma not donated or replaced.
- Casts and dressings.

For second and third surgical opinions, the plan will pay 100 percent of doctors' charges — after Medicare's payments — with no deductible. Some minor surgical procedures can be performed outside of a hospital. Ambulatory surgical centers are equipped and staffed to perform these procedures.

### **Ambulatory Surgical Center**

A specialized facility established, equipped, operated and staffed primarily for performing surgical procedures and that fully meets one of the following two tests:

- It is licensed as an ambulatory surgical center by the appropriate local regulatory authority.
- Where licensing is not required, it meets all of the following requirements:
  - It is operated under the supervision of a licensed doctor (M.D. or D.O.) who is devoting full time to supervision, and it permits a surgical procedure to be performed only by a doctor who has current privileges to perform the procedure in at least one area hospital.
  - Except for cases requiring only local infiltration of anesthetics, it requires that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist to administer the anesthetic. The anesthesiologist or anesthetist must remain present throughout the surgical procedure.
  - It provides at least one operating room and at least one postanesthesia recovery room.
  - It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services.
  - It has immediate access to a blood bank or blood supplies.
  - It has trained personnel and necessary equipment to handle emergency situations.
  - It provides full-time services of registered nurses (R.N.) for patient care in the operating rooms and in the postanesthesia recovery room.
  - It maintains an adequate medical record for each patient.
- An ambulatory surgical center can be a stand-alone facility or part of a hospital.

## Medical Supplies and Equipment

After you pay the annual deductible, the plan pays 80 percent of covered charges that remain after Medicare's payment, for the purchase of medical supplies and equipment, including:

- Casts, splints, dressings, braces and crutches.
- Intravenous (IV) infusion therapy supplies.
- Prosthetic devices, such as breast prostheses and artificial limbs and eyes (to initially replace natural body parts), and their subsequent repair and replacement if they malfunction (prosthetic devices are not covered if purchased more than once every three years).
- Initial pair of eyeglasses or contact lenses, including fitting, following surgery or accidental injury to the lens of an eye.

### Durable Medical Equipment

If you rent durable medical equipment, such as a hospital bed, a wheelchair, monitoring equipment, or an iron lung, after you pay the annual deductible, the plan can pay 80 percent of rental charges that remain after Medicare's payment, up to the amount that would be paid to buy the equipment.

The plan will only pay for the most cost-effective piece of equipment, including prosthetics, that would meet the patient's functional needs.

### Diabetic Supplies

After you pay the annual deductible, the plan pays 80 percent of the portion of covered charges that remains after Medicare's payment for blood glucose monitors, testing strips and diabetic supplies (excluding syringes, needles and insulin, which are covered under the Express Scripts Medicare™ (PDP) for diabetics, whether or not the patient uses insulin.

## Doctors' Care

After you pay the annual deductible, the plan pays 80 percent of the portion of covered charges that remains after Medicare's payment under Part B for the following services, whether provided in the doctor's office, a hospital, or an outpatient facility:

- Diagnosis and treatment (including surgery, administration of anesthesia, and other medically necessary services).
- Radiotherapy.
- Medical consultation.
- Allergy tests and treatment, including allergy shots.

### Doctor

The term "doctor" means a doctor or surgeon (M.D.), a psychiatrist (M.D.), an osteopath (D.O.), a podiatrist (D.P.M.), a dentist (D.M.D. or D.D.S.), a chiropractor (D.C.) and an ophthalmologist (O.D.).

For care to be covered under the plans, the doctor must be licensed by the proper authorities of the state in which he or she practices, and practice and treatment must be within the scope of the doctor's license.



## **Covered Therapy Treatments**

After you pay the annual deductible, the plan pays 80 percent of the portion of covered charges that remains after Medicare's payment for therapy treatments prescribed by a doctor and provided by a licensed physical, speech (when speech impediment or dysfunction results from injury, stroke or congenital anomaly), occupational or orthoptic therapist.

### **Cardiac Rehabilitation Therapy**

After you pay the annual deductible, the plan pays 80 percent of the portion of covered charges that remains after Medicare's payment for a monitored, doctor-supervised exercise program designed to help you strengthen and rehabilitate your heart following coronary bypass surgery or heart attack — or as a preventive measure to help you avoid a heart attack.

## **Nursing Care Services**

To be covered by the plan, the care you need must require the special training and skills of a nurse (defined below).

If your doctor prescribes private-duty nursing care outside the hospital, you or your doctor must notify Personal Health Support in advance; otherwise, benefits may be reduced. (Private-duty nursing in a hospital is not considered necessary because hospitals provide adequate nursing services.) If approved, the plan covers 80 percent of allowable charges, after you pay the annual deductible, for private-duty nursing care services up to a maximum benefit of \$10,000 per calendar year. Personal Health Support can be reached by calling 1-800-654-0079 on Monday through Friday between 7 a.m. and 5 p.m. Pacific time. Custodial care (defined below) isn't covered by the plan, even if it's prescribed by a doctor and provided by a nurse.

Neither the plan nor Medicare covers charges for custodial care, even if those services are recommended or prescribed by a doctor.

Medicare does cover nursing services in your home as part of a home health care program. When your doctor recommends this type of care, UnitedHealthcare's Personal Health Support at 1-800-654-0079 can help you identify Medicare providers in your area that offer nursing care as part of home health care programs.

**Nurse**

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

**Nurse-Midwife**

A registered nurse who has passed the American College of Nurse-Midwives' national exam for certification.

**Custodial Care**

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

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

**Ambulance Transportation**

The plan helps pay for emergency ambulance transportation to a hospital or skilled nursing facility. After you pay the annual deductible, the plan pays 80 percent of the portion of covered charges that remains after Medicare's payment. Benefits can also be paid for medically necessary transportation (including air transportation) from one hospital to another.

**Reconstructive Surgery**

After you pay the annual deductible, the plan pays 80 percent of the portion of covered charges that remains after Medicare's payment for reconstructive cosmetic surgery required to repair a birth defect or damage caused by an accidental injury or disfiguring disease.

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.

## Dental Care

After you pay the annual deductible, the plan pays 80 percent of the portion of covered charges that remains after Medicare's payment for the following kinds of dental care only:

- Dentists' charges for the repair or initial replacement of sound natural teeth that are damaged or lost as a result of an injury or accident, other than chewing.
- Hospital and anesthesia charges in connection with oral surgery when provided in a facility approved by Medicare.

For TMJ oral surgery described below, the plan pays 80 percent of the portion of covered charges that remains after Medicare's payment:

- **Oral Surgery** — The plan helps pay for oral surgery to correct temporomandibular joint dysfunction (TMJ). The plan pays 80 percent, up to a maximum of \$750 per calendar year, with no deductible required.
- **Other TMJ Treatments** — The Chevron Medicare Plus Plan can pay 50 percent of covered charges for certain other kinds of nonsurgical TMJ treatments, up to a maximum lifetime benefit of \$750 (lifetime limit applies to services received under the Medicare Plus Plan, Senior Care Plan and the Medicare Standard Plan combined). This includes orthotic splints and certain other kinds of TMJ treatments, but not procedures, restorations or prostheses that permanently alter the bite. You don't have to pay a deductible to receive these benefits for TMJ treatment.

## Non-U.S. Medical Services

The plan will reimburse you for 80 percent of billed charges, after the deductible, for emergency medical treatment and services incurred outside the U.S. and that are otherwise covered charges under the plan. This amount will be reduced by any amount payable under Medicare. Nonemergency medical services and travel expenses are not covered by the plan.

## Mental Health Services

The plan covers certain charges for inpatient and outpatient mental health services.

- **Inpatient Treatment** — After you pay the annual deductible, the plan pays 80 percent of the portion of covered charges that remains after Medicare's payment for inpatient mental health care, including psychiatric treatment in a hospital or skilled nursing care facility.

However, psychiatric treatment may be covered in a non-hospital residential treatment program (licensed by the proper state authorities) when it is substituted for inpatient treatment). This is a structured 24-hour program combining inpatient and outpatient treatment. Also, instead of inpatient treatment, charges for a day treatment program may be covered. Under a day treatment program, two days of outpatient treatment count as one day of inpatient treatment.

If you have concerns or questions about a mental health issue or would like a referral, you can call Chevron's Employee Assistance and WorkLife Services staff at 1-800-860-8205 or 1-925-842-3333.

- **Outpatient Treatment** — After you pay the annual deductible, the plan pays 80 percent of the portion of covered charges that remains after Medicare's payment for outpatient individual or group mental health care, including charges for visits to a psychiatrist. If you receive group therapy, each hour of group therapy treatment counts as one-half hour of outpatient treatment.

In California, charges are covered if care is provided by a "licensed psychotherapist." A licensed psychotherapist is a psychologist, a licensed clinical social worker (L.C.S.W.), or a marriage, family and child counselor (M.F.C.C.) who is practicing within the scope of a license issued by the proper state authorities.

Outside California, charges are covered if care is provided by a psychotherapist or counselor who is practicing within the scope of a license issued by the proper authorities in the state where he or she practices.

## Substance Abuse Care

Services received on an inpatient basis in a hospital or on an outpatient basis are covered at 80% of eligible expenses after satisfying the plan deductible. Covered charges for individual inpatient care include hospital and doctors' charges for hospital confinement and certain charges for outpatient and day treatment. In certain cases, day patient treatment, outpatient treatment, and structured outpatient treatment may be substituted for inpatient treatment. Covered charges for group therapy include charges provided under a doctor's direction.

### Employee Assistance and WorkLife Services (for retirees)

Chevron's Employee Assistance and WorkLife Services staff is available and can help you locate providers in your area who treat alcoholism, drug dependency, and mental health problems. You can call Employee Assistance and WorkLife Services at 1-800-860-8205 or at +1-925-842-3333 when calling from outside the U.S (call collect). All inquiries are confidential. However, if your safety or the safety of someone else is at risk, Chevron's Employee Assistance and WorkLife Services will take whatever action they deem necessary to protect you or others.

## Home Health Care Services

After you pay the annual deductible, the plan pays 80 percent of the portion of covered charges that remains after Medicare's payment for home health care services. To be covered, the services must be part of a treatment plan prescribed by the patient's doctor and must be covered by Medicare. No benefits are payable for custodial care.

**Home Health Care Agency**

A home health care agency provides services such as part-time or intermittent skilled nursing care, teaching and rehabilitation services. It also may provide rehabilitation equipment, based on a treatment plan prescribed by the patient's doctor. The agency must be certified by Medicare and participate in the federal Medicare program in order for its charges to be covered under the plan.

**Hospice Care**

After you pay the annual deductible, the plan pays 80 percent of the portion of covered charges that remains after Medicare's payment for hospice care. These benefits are payable whether covered care is provided in an approved hospice facility or in the patient's home.

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

To be eligible for the following hospice care benefits, Medicare must have approved the hospice care. Typically, the patient's physician must certify that the patient is terminally ill and has a life expectancy of six months or less. Hospice care must be ordered by a doctor, must be delivered or supervised by licensed technical or professional medical personnel, and must follow Medicare limitations.

# Expenses That Aren't Covered Under the Chevron Medicare Plus Plan

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The Chevron Medicare Plus Plan doesn't cover any of the following:

- Services and supplies provided during times you or your covered dependents were not covered under this plan.
- Services and supplies that do not meet the plan's definition of medically necessary.
- Charges in excess of the "covered charges," as defined in the plan.
- Any type of therapy, service or supply, including, but not limited to, spinal manipulations by a chiropractor or other doctor for the treatment of a condition that ceases to be therapeutic treatment, as determined by UnitedHealthcare, and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
- Custodial care services that are all of the following:
  - Are non-health-related services, such as assistance in activities of daily living (including, but not limited to, feeding, dressing, bathing, transferring and ambulating).
  - Are health-related services that do not seek significant and objective improvement, or which are provided during periods when the medical condition of the patient who requires the service is not changing.
  - Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.
- Cosmetic surgery or treatment (surgery or treatment primarily to change appearances), whether or not for psychological or emotional reasons, including confinement, treatment, services or supplies, except reconstructive surgery that's covered by Medicare.
- Services provided by any person who is a member of your immediate family or who resides in your home.
- Hospital charges for a private room that are in excess of the hospital's regular daily rate for semiprivate room accommodations.
- Private-duty nursing services while confined in a facility.
- Eye refractions (vision screenings), eyeglasses, contact lenses and supplies, hearing aids, routine hearing tests, cochlear implants, or the fitting of any of these supplies (except eye care services as described under the Vision Program), unless required by an accidental injury. surgical procedures to correct refraction errors of the eyes (for example, LASIK or PRK), including any confinement, services or supplies given in connection with, or related to, the surgery.

- Services and supplies in connection with an occupational injury or sickness. An occupational injury or sickness is an injury or sickness that is covered under a workers' compensation act or similar law or that is sustained while working for compensation, profit or gain. For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the workers' compensation act or similar law had that coverage been elected.
- Injury or other loss sustained as a result of active participation in a war or any act of war, whether war is declared or not, an international armed conflict, or a conflict involving armed forces of any international authority.
- Treatment in a U.S. government or agency hospital. However, the reasonable cost incurred by the U.S. or one of its agencies for inpatient medical care and treatment given by a hospital of the uniformed services may be covered under the plan. The cost of this inpatient medical care and treatment will be covered if the charges for the care and treatment are otherwise covered under this plan and the care and treatment were provided to any of the following:
  - A person retired from the uniformed services.
  - A family member of a person who is retired from the uniformed services.
  - A family member of a person who is active in the uniformed services.
  - A family member of a deceased member of the uniformed services.
- Expenses which you or a covered dependent is not legally required to pay. However, the reasonable cost incurred by the U.S. for medical care and treatment given to a veteran by the U.S. or one of its agencies may be covered under this plan. The cost of the care and treatment will be covered if:
  - The veteran does not have a service-related disability.
  - Charges for the care and treatment are otherwise covered under the plan.
- Education, training, and bed and board in an institution that is primarily a school, or other institution for training or a place of rest, or a domicile for the aged.
- Sensitivity training or educational training therapy or treatment for an education requirement.
- Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or for permanent loss of hair from an accidental injury), hair transplants, hair weaving, or any drug if the drug is used in connection with baldness.
- Treatment considered experimental, unproven, or investigative (as determined by the Medicare Plus Plan claims administrator), because it does not meet generally accepted standards of medical practice in the U.S. This includes any related confinement, treatment, service or supply.

- Confinement, treatment, services or supplies given for, or related to, any of the following:
  - Abdominoplasty.
  - Sex-change surgery.
  - Reversal of sterilization.
  - Nutritional counseling in a group setting.
  - Liposuction.
  - Speech therapy for fluency disorders.
  - Chelation therapy, except to treat heavy metal poisoning.
  - Tobacco dependency.
  - Massage therapy, including, but not limited to, Rolfing and acupuncture.
  - Health club membership costs and purchases of home whirlpools, spas, and saunas for any reason.
  - Tine test for tuberculosis.
  - Charges for completion of claims, missed appointments, telephone conversations or consultations, Internet visits of any type, and standby services required by a physician.
  - Herbal medicine and holistic or homeopathic care, including, but not limited to, drugs, aromatherapy, and ecological or environmental medicine.
- Personal convenience and comfort items or general household goods, including, but not limited to, purchase or rental of radios, TVs, telephones, first-aid kits, exercise equipment, air conditioners, food liquefiers, cost of meals for guests, newspapers, humidifiers, or bedside service tables.
- Benefits for durable medical equipment if repaired and/or replaced more than once every three years. Benefits for prosthetic devices if purchased more than once every three years.
- Weight reduction and control, unless accompanied by a diagnosis of severe or morbid obesity with treatment covered by Medicare. Membership costs for weight-loss clinics and similar programs and special foods, food supplements, liquid diets, diet plans, or other related products.
- Examinations and treatment ordered by a court in connection with legal proceedings, unless such examinations and treatment otherwise qualify as covered expenses.
- Charges that are payable under the federal Medicare program.
- Charges that aren't covered by the federal Medicare program, unless specified in the plan.
- Charges that exceed Medicare-approved amounts, if they're covered by Medicare.
- Nonrehabilitative education care.
- Charges for which a claim for benefits isn't filed within six months (by June 30) following the year in which the covered charge is incurred.
- Treatment or services that aren't prescribed as necessary by a doctor (although not all services or treatments prescribed by a doctor are considered covered charges).



- Any drugs, unless provided while confined in a hospital or unless they are injectable drugs that are routinely or customarily administered by a doctor or registered nurse (R.N.) in the provider's office.
- Experimental, investigational or unproven procedures, drugs or devices not considered safe and effective (as determined by the claims administrators).
- In vitro fertilization and related services.
- Transportation, other than ambulance services specifically covered under the plan.
- Dental care, except care that's specifically covered under the plan.
- Auxiliary items normally available without a prescription, even though they're recommended by a doctor (including items such as posture chairs, hot tubs, exercise bicycles and other exercise equipment).
- Routine physical exams or checkups, including X-rays and lab tests for such examinations, immunizations, and blood tests required for a marriage license.
- Payments for which you are reimbursed or are eligible to receive reimbursement as a result of any award or settlement from a third party for medical expenses resulting from an act or failure to act of the third party — including reimbursements under no-fault automobile insurance — unless you or your dependent agrees to reimburse the plan when damages are recovered from the third party.
- Treatment of an injury that results from your active participation in an insurrection, a crime, a riot, or an unlawful act.
- Immunizations for travel outside the U.S. or for occupational requirements.
- Charges for private-duty nursing care that isn't preapproved by Personal Health Support in advance.
- Charges for substance abuse treatment that isn't preapproved by Personal Health Support in advance.
- Charges for preventive care, other than preventive care specifically covered by Medicare.
- Care in a skilled nursing facility for the first 20 days or beyond 100 days in a calendar year.

# Medical Claims and Appeals

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This section describes how to file a claim for Chevron Medicare Plus Plan benefits and the claim review and appeals process that is followed whenever you submit a claim for benefits. You should be aware that UnitedHealthcare has the right to request repayment if they overpay a claim for any reason. **Note:** This information pertains to medical claims only. For information about filing vision claims, see the Vision section. For information about filing a prescription drug claim, see the Prescription Drug section. 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

When you have expenses covered under Medicare, you file a claim with Medicare and then with UnitedHealthcare (UHC), who is the claims administrator for the Medicare Plus Plan.

You should file your medical claims as you incur a covered charge, even if you haven't satisfied the plan's deductible requirement. You must submit a request for payment of benefits within six months (by June 30) following the year of the service. If you don't provide this information to the claims administrator within six months following the year of the service, benefits for that health service will be denied, according to the plan or otherwise at the claims administrator's discretion. This time limit does not apply if you are legally incapacitated. Also, this time limit doesn't apply if Medicare has not yet processed your claim. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

### Filing a Claim With Medicare

In most cases, providers under Part A and Part B, such as hospitals and physicians, submit claims to Medicare for you. You then receive an *Explanation of Medicare Benefits* statement that you can send to UnitedHealthcare (UHC) with your claim for the Chevron Medicare Plus Plan benefits.

### Filing a Claim With UHC: Medicare Crossover Program

To simplify the way you file claims for Medicare Part A and Part B expenses, UnitedHealthcare offers the Medicare Crossover program. Under this program, you or your provider sends a claim to Medicare for Part B benefits. Medicare will automatically send a copy of your *Explanation of Medicare Benefits* statement electronically to UnitedHealthcare. UnitedHealthcare then processes the remainder of the claim. You don't have to complete a Chevron Medicare Plus Plan claim form.

### **Filing a Claim With UHC: Claim Forms**

If you use a provider who does not accept Medicare or you otherwise need to file a claim, you should attach all itemized bills for medical expenses when submitting a claim form for expenses covered under the Chevron Medicare Plus Plan. There are several ways to obtain a claim form:

- Call UnitedHealthcare, the plan's claims administrator, at 1-800-654-0079.
- Access UnitedHealthcare's website at [www.myuhc.com](http://www.myuhc.com).
- Access the Benefits Connection website at [www.benefitsweb.com/chevron.html](http://www.benefitsweb.com/chevron.html).
- Call the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).

When you fill out the claim form, use your full name and include your subscriber number (which can be found on your UnitedHealthcare ID card). Attach all the bills and receipts you received for the services and supplies provided, as well as the *Explanation of Medicare Benefits* statement for a Part A covered expense. On your itemized bill, be sure to include all of the following:

- Your (the retired employee's) UnitedHealthcare subscriber number found on your UnitedHealthcare ID card.
- Name of patient (if the patient is a dependent) and, if applicable, name of the retired employee.
- Date of service.
- "Chevron Group No. 247848" printed on the face of the statement.
- Amount of charge.
- Service or treatment provided and diagnosis.
- Provider's name, address, telephone number and tax ID number.

Mail the completed form to:

UnitedHealthcare  
Chevron Group No. 247848  
P.O. Box 30555  
Salt Lake City, UT 84130-0555

You should keep photocopies of each claim, so you can keep track of your reimbursements. The claims administrator may request additional information in order to process your claim.

If you have questions about a claim, wait at least 10 working days after you send in the claim form, and then call UnitedHealthcare at 1-800-654-0079. Or you can view your claim information on the website at [www.myuhc.com](http://www.myuhc.com). **Note:** You must first register as a member to use the myuhc.com website.

After you receive your *Explanation of Medicare Benefits* statement, you should file your claim as soon as you can to ensure timely payment. If you don't file a claim within six months (by June 30) following the year in which you incur a covered charge, no plan benefits will be payable for that covered charge.

### **UnitedHealthcare Explanation of Benefits**

After your claim has been processed, you will receive an *Explanation of Benefits (EOB)* statement. The *EOB* shows all the charges that were submitted, what charges the plan covered, and the amount that was actually paid. It also provides you with an explanation of how the benefit amounts were determined and the amount of payment, if any, you're responsible for paying.

### **Payment of Claims Incurred Outside the U.S.**

Claims incurred outside the U.S. for emergency services and paid by the member in a foreign currency will be reimbursed using the "typical credit card rate plus 2 percent" as shown on [www.oanda.com](http://www.oanda.com) (a website used for currency conversion) for the date the service was incurred.

## **Initial Claim Review and Decision**

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

### **Types of Claims**

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

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

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

### **Time Limits for Processing Claims**

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

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

## Time Limits for Processing Claims

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

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

### **Concurrent Care Claims**

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

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

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

### **Notice and Payment of Claims**

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

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

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

## If Your Claim Is Denied

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

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

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

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

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

## How to File an Appeal

This section describes how to file an appeal and the time limits that apply to the different types of medical appeals.

<b>Time Limits for Processing Appeals</b>			
This chart describes the time limits for processing different types of appeals.			
Time Limits	Types of Claims		
	Urgent Care Health Claims	Preservice Health Claims	Postservice Health Claims
<b>Your deadline to file a first appeal</b>	<b>180 days</b> after receiving the claim denial notice.	<b>180 days</b> after receiving the claim denial notice.	<b>180 days</b> after receiving the claim denial notice.
<b>Plan notice of first appeal decision</b>	<b>Not later than 72 hours</b> after receiving an appeal.	<ol style="list-style-type: none"> <li><b>Not later than 15 days</b> after receiving an appeal, if the plan allows two levels of appeal.</li> <li><b>Not later than 30 days</b> after receiving an appeal, if the plan allows one level of appeal.</li> </ol>	<ol style="list-style-type: none"> <li><b>Not later than 30 days</b> after receiving an appeal, if the plan allows two levels of appeal.</li> <li><b>Not later than 60 days</b> after receiving an appeal, if the plan allows one level of appeal.</li> </ol>
<b>Your deadline to file a second appeal</b>	<b>N/A</b>	<b>90 days</b> after receiving the first appeal denial notice.	<b>90 days</b> after receiving the first appeal denial notice.
<b>Plan notice of second appeal decision</b>	<b>N/A</b>	<b>Not later than 15 days</b> after receiving a second appeal.	<b>Not later than 30 days</b> after receiving a second appeal.
<b>Your deadline to request an External Review</b>	<b>Four months</b> after receiving the appeal denial notice	<b>Four months</b> after receiving the second appeal denial notice	<b>Four months</b> after receiving the second appeal denial notice
<b>IRO notice of External Review Decision</b>	<b>Not later than 72 hours</b> after receiving the request for external review.	<b>Not later than 45 days</b> after receiving the request for external review	<b>Not later than 45 days</b> after receiving the request for external review



## First Appeal

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

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

Your appeal should include *all* of the following:

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

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

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

### Where to Send Your First Appeal

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

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

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

### **Time Limits and Procedures for Processing Your First Appeal**

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

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

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

**Notice of Decision on First Appeal**

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

If your first appeal is denied (in whole or in part), you will receive a written notice. The notice will contain information sufficient to identify the claim involved. The notice will state the reasons for the denial, including references to specific plan provisions upon which the denial was based and a statement of your right to file a civil lawsuit under Section 502(a) of ERISA following an adverse determination after completion of all levels of appeal/review required by the plan. The notice will state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

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

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

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

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

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

## Second Appeal

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

### Time Limits and Procedures for Processing Your Second Appeal

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

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

### Notice of Decision on Second Appeal

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

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

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

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

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

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

## Requesting an External Review

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

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

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

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

### Expedited External Review

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

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

To request an expedited external review, contact:

#### UnitedHealthcare

Phone: 1-800-654-0079

Fax: 1-813-818-3637

Email: Plan\_Sponsor\_Appeal\_Services@uhc.com

Mail: UnitedHealthcare

Attn Central Escalation Unit/Appeals | 601 Brooker Creek Rd | Oldsmar, FL 34677

## **Administrative Power and Responsibilities**

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

## If You're Covered by More Than One Health Plan

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Coordination of benefits is a feature used to determine how much the Chevron health plans pay when you or one of your dependents is also covered under another group health plan, including federal Medicare. This feature is designed to prevent overpayment of benefits.

**Note – there are independent Medicare plans that, as required by federal regulations, Chevron's Medicare Plus Plan cannot coordinate coverage with, for example Kelsey Seybold in Texas. You cannot be enrolled in Kelsey Seybold and also have coverage under a Chevron-sponsored Medicare plan.**

### How It Works

Under the coordination of benefits rules, one plan pays benefits first (the "primary payer") and one plan pays second (the "secondary payer"). (See below and the following pages for explanations of "primary payer" and "second payer".) The primary payer pays the benefits provided by its plan features. The secondary payer then pays any excess amounts required to bring the total benefits paid up to the levels payable under its plan. The sum of the benefits paid from each plan will not exceed the actual expense incurred. If the Chevron health plan is the secondary payer, the combined benefit from both plans won't be more than the Chevron plan's limit for the covered charges (except in some instances for the Chevron Medicare Plus Plan, the Chevron Senior Care Plan, the Chevron Dental PPO Plan, and the Prescription Drug Program). If the Chevron Dental PPO Plan is the secondary payer, plan benefits cannot be more than the negotiated fees or UCCI's allowance, but not to exceed your responsibility under the primary plan. Different coordination of benefits rules apply under different circumstances.

**For information about coordination of benefits under the Prescription Drug Program refer to the Express Scripts Medicare™ (PDP) Evidence of Coverage document, mailed separately to you each year by Express Scripts. You also can call Express Scripts at 1-800-935-6215 to request a copy.**

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

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

A plan other than your Chevron health plan will be the primary payer if any of the following conditions applies to the other plan:

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

When you or a dependent is covered under both the Chevron Dental PPO Plan and a Chevron medical plan, the Dental PPO Plan will be the primary payer for services and supplies that are covered under both plans. If the Chevron medical plan is the secondary payer, the combined benefit from both plans won't total more than the Chevron plan's limit for the covered charges.

### Here's an example of how this works:

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

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



## Coordinating Your Child's Coverage With Your Spouse's/Domestic Partner's Plan

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

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

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

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

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

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

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

## If You're Eligible for Medicare

**If you're enrolled in one of the Chevron Medical PPO Plans** and you or your dependent is eligible for federal Medicare, the Medicare-eligible person must be enrolled in the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, or the Chevron Senior Care Plan. In turn, Medicare becomes the primary payer for the Medicare-eligible person.

**Exception:** If you reside outside of the U.S. and you or your dependent is eligible for federal Medicare, the Medicare-eligible person will be enrolled in the Chevron Medical PPO Plan, and the Chevron Medical PPO Plan is the primary payer for services obtained outside of the U.S. However, in the event the Medicare-eligible person obtains services in the U.S., Medicare will be the primary payer. The Medicare-eligible person should enroll in both Part A and Part B since benefits will be calculated as though you are covered under Medicare Part A and Part B.

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

**If you're enrolled in the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, or the Chevron Senior Care Plan**, benefits payable under these plans are coordinated with benefits paid by federal Medicare. Part A and Part B of Medicare pay benefits first (the primary payer) and the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, or the Chevron Senior Care Plan pays benefits second (the secondary payer) for all charges covered under Medicare. See the earlier Chevron Medicare Plus Plan, Chevron Medicare Standard Plan, and Chevron Senior Care Plan sections for specific examples on how each plan coordinates with Medicare, as each plan coordinates with Medicare differently. Outpatient prescription drugs are covered under the Express Scripts Medicare™ (PDP), a Medicare-approved prescription drug plan. When you are enrolled in the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, or the Chevron Senior Care Plan, a few prescription drugs are also covered by Medicare Part B, such as some oral anticancer treatment drugs, immunosuppressive drugs, some diabetic supplies and some inhalation drugs. Those drugs covered by Medicare Part B also are covered by the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, and the Chevron Senior Care Plan. After Medicare benefits are paid, payments from the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, or the Chevron Senior Care Plan are coordinated with any other group insurance plan covering you or your dependents.



# Basic Vision Coverage

## Chevron Medicare Plus Plan

You and your eligible dependents have basic vision coverage under the Vision Program if you are enrolled in the Chevron Medicare Plus Plan. This program, administered by VSP, helps with the cost of eye exams.

## Highlights

### Basic Vision through VSP Vision Care (VSP)

Network	100% of the comprehensive eye exam, including dilation as needed, per calendar year.
Out-of-Network	Up to \$45 maximum reimbursement per calendar year for a comprehensive eye exam, including dilation as needed.

Discounts on eyeglasses, contact lenses and accessories are also available from VSP network providers.

## Evidence of Coverage Document

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

- VSP at 1-800-877-7195.
- Go to [www.vsp.com/go/chevron](http://www.vsp.com/go/chevron) on the internet.

## How to Use Your Basic Vision Benefit

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

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

## Basic Vision Claims

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

- VSP at 1-800-877-7195.
- Go to [www.vsp.com/go/chevron](http://www.vsp.com/go/chevron) on the internet.

You must file a claim for payment of benefits no later than 365 days from the date the service was provided. If you don't file a proper claim with VSP within this timeframe, benefits for service will be denied. If your dispute concerns eligibility to participate in the plan, you must follow the procedures described in the How to File a Claim for Eligibility section in this book.

# Prescription Drugs

## Chevron Medicare Plus Plan

You and your eligible dependents are covered by the **Express Scripts Medicare™ (PDP)** if you are enrolled in the Chevron Medicare Plus Plan. For information about the prescription drug benefits available to you, review your **Express Scripts Medicare™ (PDP) Evidence of Coverage** document, mailed separately to you each year by Express Scripts. You also can call Express Scripts at 1-800-935-6215 to request a copy.



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# Chevron Medicare Standard Plan

This section describes the Medicare Standard Plan that Chevron offers to Medicare-eligible retirees. The plan covers a broad range of medical services when combined with benefits provided by federal Medicare. The plan includes prescription drug coverage under the Express Scripts Medicare™ (PDP), a Medicare-approved prescription drug plan administered by Express Scripts. The plan also includes a Vision Program administered by VSP.

**Note:** Medicare-eligible retirees also have the option of choosing the Chevron Medicare Plus Plan or the Chevron Senior Care Plan (described in other sections) or a Medicare HMO offered by the company (if available in your area).

- Medical Coverage – UnitedHealthcare (UHC)
- Basic Vision Coverage - VSP Vision Care (VSP)
- Prescription Drug Coverage – Express Scripts

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**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.**





# Medical Coverage

## Chevron Medicare Standard Plan

The Chevron Medicare Standard Plan, hereafter referred to as the Medicare Standard Plan, is administered by UnitedHealthcare.

Depending on where you live, you may be eligible for a medical health maintenance organization (HMO) plan. If you choose an HMO for your medical coverage, you'll want to review the Medical and Dental HMO Supplement section.

## Overview of Benefits

This outline is intended to provide you with an overview of the benefits available under the plan and is not intended to be all-inclusive. Please refer to each applicable section for more detailed information about these benefits. Important terms used below are defined later under How the Plan Works; they are important for determining the benefits available under the plan. **Note:** The Chevron Medicare Standard Plan coordinates payment with Medicare. When combined with Medicare's payment, this plan's benefit will pay up to 80 percent of covered charges for most services. The benefit amount paid is determined by calculating the amount the Chevron Medicare Standard Plan would pay (generally 80 percent of covered charges after the deductible) and subtracting the amount payable by Medicare. The difference, if any, is the amount payable under the Chevron Medicare Standard Plan.

Service or Supply	What the Plan Pays
<b>Medicare Part A and Part B deductibles</b>	80% of covered charges, subject to the deductible minus the amount paid by Medicare; 100% of covered charges after \$1,500 out-of-pocket maximum per person is reached
<b>Inpatient hospitalization</b> <ul style="list-style-type: none"> <li>• Room and board at semiprivate room rate</li> <li>• Hospital-related expenses, including operating room, X-rays and lab tests.</li> </ul>	80% of covered charges subject to the deductible minus the amount paid by Medicare; 100% of covered charges after \$1,500 out-of-pocket maximum per person is reached
<b>Other medical services</b> <ul style="list-style-type: none"> <li>• Blood</li> <li>• Skilled nursing care (for the 21st through 100th day of confinement)</li> <li>• Ambulatory surgical center services</li> <li>• Medical supplies and equipment</li> <li>• Doctors' and therapists' care provided in a doctor's office, a hospital, or an outpatient facility</li> <li>• Cardiac rehabilitation therapy</li> <li>• Home health care</li> <li>• Hospice care</li> <li>• Certain nursing care services (\$10,000 maximum benefit per plan member per year) to receive benefits, patient must notify UHC Personal Health Support</li> <li>• Ambulance transportation</li> <li>• Certain kinds of reconstructive cosmetic surgery</li> <li>• Dental care, if teeth are damaged or lost due to accidental injury, other than a chewing injury</li> <li>• Mental health care, covers inpatient treatment and outpatient visits</li> <li>• Substance abuse treatment, inpatient hospital care covered; certain types of outpatient treatment covered as well</li> <li>• Inpatient and outpatient prescription drugs that are covered under Medicare Part B</li> <li>• Diabetic testing supplies</li> <li>• Prescription drugs filled on an emergency basis while traveling outside the U.S.</li> </ul>	80% of covered charges subject to the deductible minus the amount paid by Medicare; 100% of covered charges after \$1,500 out-of-pocket maximum per person is reached
<b>Second and third surgical opinions</b>	100% of covered charges in excess of federal Medicare payments

## How Much You Pay for Coverage

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If you enroll in this plan, you and Chevron currently share the cost of coverage. Your monthly contribution also depends on the number of dependents you enroll. Current rates are available from the HR Service Center. (See Appendix: Company Contributions for Retiree Health Care Coverage for more details about your coverage cost. In the Eligibility and Participation section, see Paying for Coverage for an explanation of how you pay your share of the cost of coverage.)

## How the Plan Works

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The Chevron Medicare Standard Plan coordinates payment with Medicare. When combined with Medicare's payment, this plan will pay up to 80 percent of covered charges for most services. The benefit amount paid is determined by calculating the amount the Chevron Medicare Standard Plan would pay (generally 80 percent of covered charges after the deductible) and subtracting the amount payable by Medicare. The difference, if any, is the amount payable under the Chevron Medicare Standard Plan.

If you or your covered dependents are eligible for Medicare, you should enroll in both Part A and Part B, because benefits under the Chevron Medicare Standard Plan will be calculated as though you are covered under Medicare Part A and Part B.

In addition, the plan covers a few services that are not covered by federal Medicare. (See *When Charges Are Covered Only by the Medicare Standard Plan* for an explanation of how benefits are calculated when care is covered only under the Chevron Medicare Standard Plan — and not by federal Medicare.)

### Covered Charges

The amount of any benefit paid under this plan is determined based on the charges recognized by the plan. These recognized charges are called *covered charges*.

With the exception of prescription drugs and the Vision Program benefits, covered charges under the plan will either be the Medicare-approved amount (defined below) or the allowable charge (defined later in this section), depending on the situation.

Covered charges for services and supplies covered by this plan and also covered by Medicare always will be based on the Medicare-approved amount. A service or supply covered under this plan must be used for the treatment of a nonoccupational sickness or injury provided under the care or direction of a doctor.

**When the provider accepts Medicare assignment** of benefits, covered charges for any benefits payable under the Chevron Medicare Standard Plan, if any, will be based on the actual Medicare-approved amount.

**When the provider does not accept Medicare assignment** of benefits, covered charges for benefits payable under the Chevron Medicare Standard Plan, if any, will be based on the maximum amount Medicare permits providers to charge for covered services, currently 115 percent of the Medicare-approved amount.

Covered charges for all other services and supplies that are covered under the Chevron Medicare Standard Plan and not covered by Medicare, like private-duty nursing care, will always be based on the allowable charge.

### Incurred Expenses

Covered medical expenses that you or your dependents incur will be covered under this plan, provided coverage is in effect on the date you or your dependents incur the medical expense. Covered medical expenses are considered incurred on the date the service is rendered or the date the product or supply is furnished.

The plan covers only services or supplies that are considered medically necessary (as defined below) for the diagnosis, treatment, or care of a sickness or injury. The plan doesn't pay for certain services, as explained under Expenses That Aren't Covered under the Chevron Medicare Standard Plan section.

### **Medically Necessary**

This term generally refers to health care services and supplies that are determined by the claims administrator, in its sole discretion, to be medically appropriate and that are all of the following:

- Necessary to meet the basic health needs of the plan member or covered dependent.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the health care service or supply.
- Consistent in type, frequency and duration with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the claims administrator as to the type, frequency and duration of treatment.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the comfort or convenience of the patient, the patient's family, the doctor or other provider.
- Demonstrated through prevailing peer-reviewed medical literature to be either of the following:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed.
  - Safe, with promising efficacy for treating a life-threatening sickness or condition, provided in a clinically controlled research setting, and using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

For purposes of this definition, the term "life-threatening" is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment. The fact that a doctor has performed, prescribed, ordered, recommended or approved a procedure or treatment, or the fact that it may be the only treatment for a particular illness, injury or pregnancy doesn't mean that it's medically necessary and appropriate as defined above.

### **Therapeutic vs. Maintenance Care**

There may come a time in treatment — for example, in the case of chiropractic care and speech, physical, orthoptic and occupational therapies — when the care provided ceases to be "therapeutic" and instead is administered to "maintain" a level of functioning. Maintenance care does not satisfy the Chevron Medicare Standard Plan's definition of a covered health service and, therefore, is not covered under the plan.

# Deductibles

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Your deductible is the amount of covered health care charges you pay each calendar year before the plan begins paying its share of those charges.

- The annual medical expense deductible is \$300 for each covered person.
- This deductible is in addition to the Medicare deductible and the Express Scripts Medicare™ (PDP) deductible.
- After you pay your deductible, the plan pays a percentage of covered charges for the care you need, and you pay any costs above the amount paid by the plan. Note that the Chevron Medicare Standard Plan pays a benefit only if the calculated benefit amount is greater than the amount already paid by Medicare.

## Expenses That Don't Count Toward Deductibles

Your deductible expenses don't count toward the out-of-pocket maximum amount, and the following expenses don't count toward your deductibles:

- Charges in excess of covered charges.
- Charges for services or supplies that aren't medically necessary.
- Charges for services or supplies that aren't covered under the plan.
- Your share of the cost of medication purchased through the Express Scripts Medicare™ (PDP).
- Your share of the cost for eyewear, exams, or other vision products purchased through the plan's Vision Program.
- Expenses you pay because you didn't get advance approval for private-duty nursing.
- Expenses you pay because you didn't get advance approval for substance abuse treatment.

# Annual Out-of-Pocket Maximum

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Under the out-of-pocket maximum feature for medical plan expenses, after your out-of-pocket costs reach \$1,500 for each covered person, the plan pays 100 percent of all covered charges until the end of the calendar year. Charges covered under the Express Scripts Medicare™ (PDP) Medco Medicare Prescription Plan and the Vision Program do not count toward your out-of-pocket maximum. (Keep in mind the Express Scripts Medicare™ (PDP) has a separate annual out-of-pocket limit for each covered person.)

## Expenses That Don't Count Toward the Out-of-Pocket Maximum Amount

Your deductible expenses don't count toward the out-of-pocket maximum amount, and the following expenses don't count toward either deductibles or the out-of-pocket maximum amount:

- Charges in excess of covered charges.
- Charges for services or supplies that aren't medically necessary.
- Charges for services or supplies that aren't covered under the plan.
- Your share of the cost of medication purchased through the Express Scripts Medicare™ (PDP).
- Your share of the cost for eyewear, exams, or other vision products purchased through the plan's Vision Program.
- Expenses you pay because you didn't get advance approval for private-duty nursing.
- Expenses you pay because you didn't get advance approval for substance abuse treatment.



# When Charges Are Covered by Both Federal Medicare and the Chevron Medicare Standard Plan

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When charges for health care are covered by both federal Medicare and the Chevron Medicare Standard Plan, benefits under the Chevron Medicare Standard Plan are based on Medicare-approved charges. The method for determining benefits depends on whether your health care provider accepts Medicare's "assignment" of approved charges.

When health care providers accept assignment, they agree to accept Medicare's guidelines of the approved charge for the services rendered (even if Medicare's approved charge is less than the actual charge).

When providers don't accept Medicare's approved charge for their services, there's a federal limit on the amount they can receive for their services. Under current law, the maximum amount they can receive is 115 percent of Medicare's approved charge.

## Medicare-Approved Amount (or Medicare-Approved Charge)

The Medicare-approved amount or charge is the charge on which Medicare bases its payment. In most cases, Medicare's approved amount will be less than the allowable charge.

Here are two examples that show how Chevron Medicare Standard Plan benefits are calculated when a provider accepts assignment — and when a provider doesn't accept assignment.

## When Your Health Care Provider Accepts Assignment

When your health care provider accepts assignment, the Medicare-approved amount is the maximum "covered charge" under the Chevron Medicare Standard Plan. The Chevron Medicare Standard Plan calculates the benefit amount (which for most services is 80 percent of covered charges after the deductible is met) and subtracts the amount payable by Medicare. The difference, if any, is the amount payable by the Chevron Medicare Standard Plan.

Assume that a doctor's usual charge for a service is \$220 and the Medicare-approved amount for the service is \$200. Medicare pays 80 percent of the approved amount (after Medicare deductibles have been paid), or \$160 ( $\$200 \times 80\% = \$160$ ).

Here's how to calculate the Chevron Medicare Standard Plan benefit:

**Step 1.** Calculate the Chevron Medicare Standard Plan benefit payment, which equals 80 percent of the Medicare-approved amount, assuming the deductible has already been met ( $\$200 \times 80\% = \$160$ ).

**Step 2.** Subtract the amount payable by Medicare from the calculated benefit payment amount ( $\$160 - \$160 = \$0$ ).

**Step 3.** The difference is the amount paid by the Chevron Medicare Standard Plan ( $\$0$ ).

In this example, Medicare pays \$160, the Chevron Medicare Standard Plan pays \$0, and you pay \$40, for a total of \$200 (the covered charge under the Chevron Medicare Standard Plan).

## When Your Health Care Provider Doesn't Accept Assignment

When your health care provider doesn't accept assignment, benefits under the Chevron Medicare Standard Plan are usually based on the federal limit on what providers can be paid for their services — 115 percent of the Medicare-approved amount (or the actual charge, if less).

Assume that a doctor's actual charge for a service is \$220, that the Medicare-approved amount is \$200, and that Medicare pays 80 percent of this amount, or \$160 ( $\$200 \times 80\% = \$160$ ), after deductibles have been met.

Here's how to calculate the Chevron Medicare Standard Plan benefit:

**Step 1.** Determine the "covered charge" under the Chevron Medicare Standard Plan as follows:

- a. Multiply the Medicare-approved charge by 115 percent ( $\$200 \times 115\% = \$230$ ).
- b. The lower amount — the result of 1a. or the doctor's actual charge — is the covered charge under the Chevron Medicare Standard Plan. (In this case, the lower amount is the doctor's actual charge of \$220).

**Step 2.** Calculate the Chevron Medicare Standard Plan benefit payment, which equals 80 percent of the lower of the Medicare-approved amount or the doctor's actual charge, assuming the deductible has already been met ( $\$220 \times 80\% = \$176$ ).

**Step 3.** Subtract the amount payable by Medicare from the calculated benefit payment amount ( $\$176 - \$160 = \$16$ ).

**Step 4.** Calculate your share of the cost by taking the total charge and subtracting the Medicare payment and the plan payment ( $\$220 - \$160 - \$16 = \$44$ ).

In this example, Medicare pays \$160, the Chevron Medicare Standard Plan pays \$16, and you pay \$44, for a total of \$220 (the covered charge under the Chevron Medicare Standard Plan).

## When Charges Are Covered Only by the Medicare Plus Plan

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When charges are covered by the Chevron Medicare Standard Plan — but not by federal Medicare — the plan’s “allowable charge” limits apply. The plan’s claims administrator determines whether a charge is allowable, as explained below. If a charge is more than the allowable amount, the excess charges are not covered under the plan.

### **Allowable Charge**

Allowable charge means an amount measured and determined by the claims administrator by comparing the actual charge for a service or supply with the prevailing charges made for it. The claims administrator, in its sole discretion, determines the prevailing charge, taking into account pertinent factors including, but not limited to:

- The Medicare-approved amount for such service.
- The complexity of the service.
- The range of services provided.
- The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

Allowable charges for prescription drug and vision claims will be determined separately (if applicable) by the claims administrators of the Express Scripts Medicare™ (PDP) and the Vision Program.

### **Predetermination of Benefits**

If you’re uncertain whether a service will be covered by the plan, in advance of treatment you or your doctor should contact UnitedHealthcare at 1-800-654-0079. A representative will let you know what services are covered.

## Covered Health Care Services

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The Chevron Medicare Standard Plan coordinates payment with Medicare. When combined with Medicare's payment, this plan's benefit will pay up to 80 percent of covered charges for most services. The benefit amount paid is determined by calculating the amount the Chevron Medicare Standard Plan would pay (generally 80 percent of covered charges after the deductible) and subtracting the amount payable by Medicare. The difference, if any, is the amount payable under the Chevron Medicare Standard Plan.

### **Hospital Room and Board, Services and Supplies**

The plan pays 80 percent of covered room and board charges (excluding additional charges for personal items such as telephones, radios and televisions), subject to the deductible minus the amount paid by Medicare. The plan also pays 80 percent of covered charges for the following hospital services and supplies related to a hospital stay subject to the deductible minus the amount paid by Medicare:

The plan also pays for the following hospital services and supplies related to a hospital stay:

- Operating room.
- X-rays and lab tests.
- Drugs, injections, oxygen, anesthesia supplies, blood and blood plasma (if not donated or replaced), and charges associated with providing these supplies.
- Intensive care unit, cardiac care unit, and isolation room charges in excess of the semiprivate room rate.
- Outpatient hospital charges, including charges for emergency room care.

## Hospital

A hospital must meet one of the following requirements:

- A legally constituted and operated institution having, on its premises, organized facilities (including diagnostic and major surgical facilities) for the care and treatment of sick and injured people. Care must be supervised by a staff of legally qualified doctors, and there must be a registered nurse (R.N.) on duty at all times.
- A free-standing rehabilitative facility that meets *all* of the following criteria:
  - Has a provider agreement, as required by Medicare;
  - Serves an inpatient population, with at least 75 percent of patients needing intensive rehabilitative services for the treatment of a stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of the femur, brain injury, polyarthritis, neurological disorders and burns;
  - Has a preadmission screening procedure to determine whether the patient would benefit from an intensive inpatient hospital program;
  - Ensures that patients receive close medical supervision and furnishes rehabilitation nursing, physical therapy and occupational therapy by qualified personnel;
  - Has a director of rehabilitation who is a doctor;
  - Establishes a plan of treatment for every patient that is reviewed as needed by a doctor who consults with other qualified personnel;
  - Uses a coordinated team approach to rehabilitate each patient.

The term “hospital” doesn’t include any of the following facilities:

- Any institution used primarily as a rest or nursing facility.
- Any facility solely for use by the aged or the chronically ill or by convalescents, drug addicts or alcoholics.
- Any facility providing primarily educational or custodial care (defined under Nursing Care Services in this section).

## Inpatient Childbirth

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).

## Skilled Nursing Facility Care

Skilled nursing facilities offer an alternative to hospitals as a place where you can recuperate. After you pay the annual deductible, the plan pays 80 percent of Medicare-approved charges minus the amount paid by Medicare for days 21–100 in each benefit period. Medicare pays for the first 20 days. The Chevron Medicare Standard Plan does not cover the first 20 days of care in a skilled nursing facility, or care beyond 100 days. Covered charges in a skilled nursing facility include:

- Semiprivate room.
- Skilled nursing care.
- Medical supplies and equipment.
- Prescribed drugs and biologicals.

Charges can be covered if all of the following conditions are met:

- A doctor recommends confinement to this type of facility.
- The facility is a Medicare provider, the services are covered by Medicare, and the services are provided in a bed designated by the facility as a Medicare bed.
- The patient would have to be confined to a hospital if the skilled nursing facility services weren't used.

### Skilled Nursing Facility

An institution that charges a fee and meets *all* of the following requirements:

- It furnishes room and board and nursing services for medical care.
- It has one or more licensed nurses on duty at all times, working under the constant supervision of a registered nurse (R.N.) or licensed doctor.
- It has available, at all times, the services of a licensed doctor.
- It complies with all legal requirements applicable to the operation of such an institution.
- It maintains medical records on all its patients at all times.
- It's approved under Medicare.

The term "skilled nursing facility" doesn't include any of the following:

- An institution used primarily as a rest facility.
- Facilities for the aged, for drug addicts, or for alcoholics.
- Facilities provided primarily for custodial or educational care.

## Ambulatory Surgical Center Services

After you pay the annual deductible, the plan pays 80 percent of covered charges minus the amount paid by Medicare for outpatient surgery for:

- Use of an operating room.
- Diagnostic X-rays and lab tests.
- Oxygen.
- Anesthesia supplies.
- Blood and blood plasma not donated or replaced.
- Casts and dressings.

For second and third surgical opinions, the plan will pay 100 percent of doctors' charges — after Medicare's payments — with no deductible. Some minor surgical procedures can be performed outside of a hospital. Ambulatory surgical centers are equipped and staffed to perform these procedures.

### Ambulatory Surgical Center

A specialized facility established, equipped, operated and staffed primarily for performing surgical procedures and that fully meets one of the following two tests:

- It is licensed as an ambulatory surgical center by the appropriate local regulatory authority.
- Where licensing is not required, it meets *all* of the following requirements:
  - It is operated under the supervision of a licensed doctor (M.D. or D.O.) who is devoting full time to supervision, and it permits a surgical procedure to be performed only by a doctor who has current privileges to perform the procedure in at least one area hospital.
  - Except for cases requiring only local infiltration of anesthetics, it requires that a licensed anesthesiologist administer the anesthetic or supervise an anesthesiologist to administer the anesthetic. The anesthesiologist or anesthesiologist must remain present throughout the surgical procedure.
  - It provides at least one operating room and at least one postanesthesia recovery room.
  - It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services.
  - It has immediate access to a blood bank or blood supplies.
  - It has trained personnel and necessary equipment to handle emergency situations.
  - It provides full-time services of registered nurses (R.N.) for patient care in the operating rooms and in the postanesthesia recovery room.
  - It maintains an adequate medical record for each patient.
- An ambulatory surgical center can be a stand-alone facility or part of a hospital.

## Medical Supplies and Equipment

After you pay the annual deductible, the plan pays 80 percent of covered charges minus the amount paid by Medicare for the purchase of medical supplies and equipment, including:

- Casts, splints, dressings, braces and crutches.
- Intravenous (IV) infusion therapy supplies.
- Prosthetic devices, such as breast prostheses and artificial limbs and eyes (to initially replace natural body parts), and their subsequent repair and replacement if they malfunction (prosthetic devices are not covered if purchased more than once every three years).
- Initial pair of eyeglasses or contact lenses, including fitting, following surgery or accidental injury to the lens of an eye.

## Durable Medical Equipment

If you rent durable medical equipment, such as a hospital bed, a wheelchair, monitoring equipment, or an iron lung, after you pay the annual deductible, the plan can pay 80 percent of rental charges, or purchase of equipment if less, minus the amount paid by Medicare. The plan will only pay for the most cost-effective piece of equipment, including prosthetics, that would meet the patient's functional needs.

## Diabetic Supplies

After you pay the annual deductible, the plan pays 80 percent minus the amount paid by Medicare for covered charges for blood glucose monitors, testing strips and diabetic supplies {excluding syringes, needles and insulin, which are covered under the Express Scripts Medicare™ (PDP)} for diabetics, whether or not the patient uses insulin.

## Doctors' Care

After you pay the annual deductible, the plan pays 80 percent of covered charges minus the amount paid by Medicare for the following services, whether provided in the doctor's office, a hospital, or an outpatient facility:

- Diagnosis and treatment (including surgery, administration of anesthesia, and other medically necessary services).
- Radiotherapy.
- Medical consultation.
- Allergy tests and treatment, including allergy shots.

### Doctor

The term "doctor" means a doctor or surgeon (M.D.), a psychiatrist (M.D.), an osteopath (D.O.), a podiatrist (D.P.M.), a dentist (D.M.D. or D.D.S.), a chiropractor (D.C.) and an ophthalmologist (O.D.).

For care to be covered under the plans, the doctor must be licensed by the proper authorities of the state in which he or she practices, and practice and treatment must be within the scope of the doctor's license.



## Covered Therapy Treatments

After you pay the annual deductible, the plan pays 80 percent of covered charges minus the amount paid by Medicare for therapy treatments prescribed by a doctor and provided by a licensed physical, speech (when speech impediment or dysfunction results from injury, stroke or congenital anomaly), occupational or orthoptic therapist.

### Cardiac Rehabilitation Therapy

After you pay the annual deductible, the plan pays 80 percent of covered charges minus the amount paid by Medicare for a monitored, doctor-supervised exercise program designed to help you strengthen and rehabilitate your heart following coronary bypass surgery or heart attack — or as a preventive measure to help you avoid a heart attack.

## Nursing Care Services

To be covered by the plan, the care you need must require the special training and skills of a nurse (defined below).

If your doctor prescribes private-duty nursing care outside the hospital, you or your doctor must notify Personal Health Support in advance; otherwise, benefits may be reduced. (Private-duty nursing in a hospital is not considered necessary because hospitals provide adequate nursing services.) If approved, the plan covers 80 percent of allowable charges, after you pay the annual deductible, for private-duty nursing care services up to a maximum benefit of \$10,000 per calendar year. Personal Health Support can be reached by calling 1-800-654-0079 on Monday through Friday between 7 a.m. and 5 p.m. Pacific time. Custodial care (defined below) isn't covered by the plan, even if it's prescribed by a doctor and provided by a nurse. Neither the plan nor Medicare covers charges for custodial care, even if those services are recommended or prescribed by a doctor.

Medicare does cover nursing services in your home as part of a home health care program. When your doctor recommends this type of care, UnitedHealthcare's Personal Health Support at 1-800-654-0079 can help you identify Medicare providers in your area that offer nursing care as part of home health care programs.

### Nurse

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

### Nurse-Midwife

A registered nurse who has passed the American College of Nurse-Midwives' national exam for certification.

### Custodial Care

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

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

## Ambulance Transportation

The plan helps pay for emergency ambulance transportation to a hospital or skilled nursing facility. After you pay the annual deductible, the plan pays 80 percent of covered charges minus the amount paid by Medicare. Benefits can also be paid for medically necessary transportation (including air transportation) from one hospital to another.

## Reconstructive Surgery

After you pay the annual deductible, the plan pays 80 percent of covered charges minus the amount paid by Medicare for reconstructive cosmetic surgery required to repair a birth defect or damage caused by an accidental injury or disfiguring disease.

- 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.

## Dental Care

After you pay the annual deductible, the plan pays 80 percent of covered charges minus the amount paid by Medicare for the following kinds of dental care only:

- Dentists' charges for the repair or initial replacement of sound natural teeth that are damaged or lost as a result of an injury or accident other than a chewing injury.
- Hospital and anesthesia charges in connection with oral surgery when provided in a facility approved by Medicare.

For TMJ oral surgery described below, the plan pays 80 percent of covered charges minus the amount paid by Medicare:

- **Oral Surgery** — The plan helps pay for oral surgery to correct temporomandibular joint dysfunction (TMJ). This plan pays 80 percent, up to a maximum of \$750 per calendar year, with no deductible required.
- **Other TMJ Treatments** — The Chevron Medicare Standard Plan can pay 50 percent of covered charges for certain other kinds of TMJ treatments, up to a maximum lifetime benefit of \$750 (lifetime limit applies to services received under the Medicare Plus Plan, Senior Care Plan and the Medicare Standard Plan combined). This includes orthotic splints and certain other kinds of TMJ treatments, but not procedures, restorations or prostheses that permanently alter the bite. You don't have to pay a deductible to receive these benefits for TMJ treatment.

## Non-U.S. Medical Services

The plan will reimburse you for 80 percent of billed charges, after the deductible, for emergency medical treatment and services incurred outside the U.S. and that are otherwise covered charges under the plan. This amount will be reduced by any amount payable under Medicare. Nonemergency medical services and travel expenses are not covered by the plan.

## Mental Health Services

The plan covers certain charges for inpatient and outpatient mental health services.

- **Inpatient Treatment** — After you pay the annual deductible, the plan pays 80 percent of covered charges minus the amount paid by Medicare for inpatient mental health care, including psychiatric treatment in a hospital or skilled nursing care facility.

However, psychiatric treatment may be covered in a non-hospital residential treatment program (licensed by the proper state authorities) when it is substituted for inpatient treatment). This is a structured 24-hour program combining inpatient and outpatient treatment. Also, instead of inpatient treatment, charges for a day treatment program may be covered. Under a day treatment program, two days of outpatient treatment count as one day of inpatient treatment.

If you have concerns or questions about a mental health issue or would like a referral, retirees can call Chevron's Employee Assistance and WorkLife Services staff at 1-800-860-8205 or 1-925-842-3333.

- **Outpatient Treatment** — After you pay the annual deductible, the plan pays 80 percent of covered charges minus the amount paid by Medicare for outpatient individual or group mental health care, including charges for visits to a psychiatrist . If you receive group therapy, each hour of group therapy treatment counts as one-half hour of outpatient treatment.

In California, charges are covered if care is provided by a "licensed psychotherapist." A licensed psychotherapist is a psychologist, a licensed clinical social worker (L.C.S.W.), or a marriage, family and child counselor (M.F.C.C.) who is practicing within the scope of a license issued by the proper state authorities.

Outside California, charges are covered if care is provided by a psychotherapist or counselor who is practicing within the scope of a license issued by the proper authorities in the state where he or she practices.

## Substance Abuse Care

Services received on an inpatient basis in a hospital or on an outpatient basis are covered at 80% of eligible expenses after satisfying the plan deductible. Covered charges for individual inpatient care include hospital and doctors' charges for hospital confinement and certain charges for outpatient and day treatment.. In certain cases, day patient treatment, outpatient treatment, and structured outpatient treatment may be substituted for inpatient treatment. Covered charges for group therapy include charges provided under a doctor's direction.

### Employee Assistance and WorkLife Services (for retirees)

Chevron's Employee Assistance and WorkLife Services staff is available and can help you identify providers who treat alcoholism, drug dependency, and mental health problems. You can call Employee Assistance and WorkLife Services at 1-800-860-8205 or at +1-925-842-3333 when calling from outside the U.S (call collect). All inquiries are confidential.

## Home Health Care Services

After you pay the annual deductible, the plan pays 80 percent of covered charges minus the amount paid by Medicare for home health care services. To be covered, the services must be part of a treatment plan prescribed by the patient's doctor and must be covered by Medicare. No benefits are payable for custodial care.

### Home Health Care Agency

A home health care agency provides services such as part-time or intermittent skilled nursing care, teaching and rehabilitation services. It also may provide rehabilitation equipment, based on a treatment plan prescribed by the patient's doctor. The agency must be certified by Medicare and participate in the federal Medicare program in order for its charges to be covered under the plan.

## Hospice Care

After you pay the annual deductible, the plan pays 80 percent of covered charges minus the amount paid by Medicare for hospice care. These benefits are payable whether covered care is provided in an approved hospice facility or in the patient's home.

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

To be eligible for the following hospice care benefits, Medicare must have approved the hospice care. Typically, the patient's physician must certify that the patient is terminally ill and has a life expectancy of six months or less. Hospice care must be ordered by a doctor, must be delivered or supervised by licensed technical or professional medical personnel, and must follow Medicare limitations.

## Expenses That Aren't Covered Under the Chevron Medicare Standard Plan

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In addition to the limitations detailed in previous sections, there are other expenses not covered under this plan. The following list of benefit exclusions is not all-inclusive. UnitedHealthcare may determine that other specific expenses are not covered under the plan. If you have a question about a specific service, you should contact UnitedHealthcare. The Chevron Medicare Standard Plan doesn't cover any of the following:

- Services and supplies provided during times you or your covered dependents were not covered under this plan.
- Services and supplies that do not meet the plan's definition of medically necessary.
- Charges in excess of the "covered charges," as defined in the plan.
- Any type of therapy, service or supply, including, but not limited to, spinal manipulations by a chiropractor or other doctor for the treatment of a condition that ceases to be therapeutic treatment, as determined by UnitedHealthcare, and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
- Custodial care services that are all of the following:
  - Are non-health-related services, such as assistance in activities of daily living (including, but not limited to, feeding, dressing, bathing, transferring and ambulating).
  - Are health-related services that do not seek significant and objective improvement, or which are provided during periods when the medical condition of the patient who requires the service is not changing.
  - Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.
- Cosmetic surgery or treatment (surgery or treatment primarily to change appearances), whether or not for psychological or emotional reasons, including confinement, treatment, services or supplies, except reconstructive surgery that's covered by Medicare.
- Services provided by any person who is a member of your immediate family or who resides in your home.
- Hospital charges for a private room that are in excess of the hospital's regular daily rate for semiprivate room accommodations.
- Private-duty nursing services while confined in a facility.
- Eye refractions (vision screenings), eyeglasses, contact lenses and supplies, hearing aids, routine hearing tests, cochlear implants, or the fitting of any of these supplies (except eye care services as described under the Vision Program), unless required by an accidental injury.
- Surgical procedures to correct refraction errors of the eyes (for example, LASIK or PRK), including any confinement, services or supplies given in connection with, or related to, the surgery.

- Services and supplies in connection with an occupational injury or sickness. An occupational injury or sickness is an injury or sickness that is covered under a workers' compensation act or similar law or that is sustained while working for compensation, profit or gain. For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the workers' compensation act or similar law had that coverage been elected.
- Injury or other loss sustained as a result of active participation in a war or any act of war, whether war is declared or not, an international armed conflict, or a conflict involving armed forces of any international authority.
- Treatment in a U.S. government or agency hospital. However, the reasonable cost incurred by the U.S. or one of its agencies for inpatient medical care and treatment given by a hospital of the uniformed services may be covered under the plan. The cost of this inpatient medical care and treatment will be covered if the charges for the care and treatment are otherwise covered under this plan and the care and treatment were provided to any of the following:
  - A person retired from the uniformed services.
  - A family member of a person who is retired from the uniformed services.
  - A family member of a person who is active in the uniformed services.
  - A family member of a deceased member of the uniformed services.
- Expenses which you, yourself, are not legally required to pay. However, the reasonable cost incurred by the U.S. for medical care and treatment given to a veteran by the U.S. or one of its agencies may be covered under this plan. The cost of the care and treatment will be covered if:
  - The veteran does not have a service-related disability.
  - Charges for the care and treatment are otherwise covered under the plan.
- Education, training, and bed and board in an institution that is primarily a school, or other institution for training or a place of rest, or a domicile for the aged.
- Sensitivity training or educational training therapy or treatment for an education requirement.
- Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or for permanent loss of hair from an accidental injury), hair transplants, hair weaving, or any drug if the drug is used in connection with baldness.
- Treatment considered experimental, unproven, or investigative (as determined by the Medicare Standard claims administrator), because it does not meet generally accepted standards of medical practice in the U.S. This includes any related confinement, treatment, service or supply.
- Confinement, treatment, services or supplies given for, or related to, any of the following:
  - Abdominoplasty.
  - Sex-change surgery.
  - Reversal of sterilization.
  - Nutritional counseling in a group setting.
  - Liposuction.
  - Speech therapy for fluency disorders.
  - Chelation therapy, except to treat heavy metal poisoning.

- Tobacco dependency.
- Massage therapy, including, but not limited to, Rolfing and acupuncture.
- Health club membership costs and purchases of home whirlpools, spas, and saunas for any reason.
- Tine test for tuberculosis.
- Charges for completion of claims, missed appointments, telephone conversations or consultations, Internet visits of any type, and standby services required by a physician.
- Herbal medicine and holistic or homeopathic care, including, but not limited to, drugs, aromatherapy, and ecological or environmental medicine.
- Personal convenience and comfort items or general household goods, including, but not limited to, purchase or rental of radios, TVs, telephones, first-aid kits, exercise equipment, air conditioners, food liquefiers, cost of meals for guests, newspapers, humidifiers, or bedside service tables.
- Benefits for durable medical equipment if repaired and/or replaced more than once every three years. benefits for prosthetic devices if purchased more than once every three years.
- Weight reduction and control, unless accompanied by a diagnosis of severe or morbid obesity with treatment covered by Medicare. membership costs for weight-loss clinics and similar programs and special foods, food supplements, liquid diets, diet plans, or other related products.
- Examinations and treatment ordered by a court in connection with legal proceedings, unless such examinations and treatment otherwise qualify as covered expenses.
- Charges that are payable under the federal Medicare program.
- Charges that aren't covered by the federal Medicare program, unless specified in the plan.
- Charges that exceed Medicare-approved amounts, if they're covered by Medicare.
- Nonrehabilitative education care.
- Charges for which a claim for benefits isn't filed within six months (by June 30) following the year in which the covered charge is incurred.
- Treatment or services that aren't prescribed as necessary by a doctor (although not all services or treatments prescribed by a doctor are considered covered charges).
- Any drugs, unless provided while confined in a hospital or unless they are injectable drugs that are routinely or customarily administered by a doctor or registered nurse (R.N.) in the provider's office.
- Experimental procedures, drugs or devices not considered safe and effective (as determined by the claims administrators).
- In vitro fertilization and related services.
- Transportation, other than ambulance services specifically covered under the plan.
- Dental care, except care that's specifically covered under the plan.

- Auxiliary items normally available without a prescription, even though they're recommended by a doctor (including items such as posture chairs, hot tubs, exercise bicycles and other exercise equipment).
- Routine physical exams or checkups, including X-rays and lab tests for such examinations, immunizations, and blood tests required for a marriage license.
- Payments for which you are reimbursed or are eligible to receive reimbursement as a result of any award or settlement from a third party for medical expenses resulting from an act or failure to act of the third party — including reimbursements under no-fault automobile insurance — unless you or your dependent agrees to reimburse the plan when damages are recovered from the third party.
- Treatment of an injury that results from your active participation in an insurrection, a crime, a riot, or an unlawful act.
- Immunizations for travel outside the U.S. or for occupational requirements.
- Charges for private-duty nursing care that isn't preapproved by Personal Health Support in advance.
- Charges for substance abuse treatment that isn't preapproved by Personal Health Support in advance.
- Charges for preventive care, other than preventive care specifically covered by Medicare.
- Care in a skilled nursing facility for the first 20 days or beyond 100 days in a calendar year.



# Medical Claims and Appeals

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This section describes how to file a claim for Chevron Medicare Standard Plan benefits and the claim review and appeals process that is followed whenever you submit a claim for benefits. You should be aware that UnitedHealthcare has the right to request repayment if they overpay a claim for any reason.

**Note:** This information pertains to medical claims only. For information about filing vision claims, see the Vision section. For information about filing a prescription drug claim, see the Prescription Drug section. 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

When you have expenses covered under Medicare, you file a claim with Medicare and then with UnitedHealthcare, who is the claims administrator for the Medicare Plus Plan.

You should file your medical claims as you incur a covered charge, even if you haven't satisfied the plan's deductible requirement. You must submit a request for payment of benefits within six months (by June 30) following the year of the service. If you don't provide this information to the claims administrator within six months following the year of the service, benefits for that health service will be denied, according to the plan or otherwise at the claims administrator's discretion. This time limit does not apply if you are legally incapacitated. Also, this time limit doesn't apply if Medicare has not yet processed your claim. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

### Filing a Claim With Medicare

In most cases, providers under Part A and Part B, such as hospitals and physicians, submit claims to Medicare for you. You then receive an *Explanation of Medicare Benefits* statement that you can send to UnitedHealthcare with your claim for the Chevron Medicare Standard Plan benefits.

### Filing a Claim With UHC: Medicare Crossover Program

To simplify the way you file claims for Medicare Part A and Part B expenses, UnitedHealthcare offers the Medicare Crossover program. Under this program, you or your provider sends a claim to Medicare for Part A and Part B benefits. Medicare will automatically send a copy of your *Explanation of Medicare Benefits* statement electronically to UnitedHealthcare. UnitedHealthcare then processes the remainder of the claim. You don't have to complete a Chevron Medicare Standard Plan claim form.

### **Filing a Claim With UHC: Claim Forms**

If you use a provider who does not accept Medicare or you otherwise need to file a claim, you should attach all itemized bills for medical expenses when submitting a claim form for expenses covered under the Chevron Medicare Standard Plan. There are several ways to obtain a claim form:

- Call UnitedHealthcare, the plan's claims administrator, at 1-800-654-0079.
- Access UnitedHealthcare's website at [www.myuhc.com](http://www.myuhc.com).
- Access the Benefits Connection website at [www.benefitsweb.com/chevron.html](http://www.benefitsweb.com/chevron.html).
- Call the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).

When you fill out the claim form, use your full name and include your subscriber number (which can be found on your UnitedHealthcare ID card). Attach all the bills and receipts you received for the services and supplies provided, as well as the *Explanation of Medicare Benefits* statement for a Part A covered expense. On your itemized bill, be sure to include all of the following:

- Your (the retired employee's) UnitedHealthcare subscriber number found on your UnitedHealthcare ID card.
- Name of patient (if the patient is a dependent) and, if applicable, name of the retired employee.
- Date of service.
- "Chevron Group No. 247848" printed on the face of the statement.
- Amount of charge.
- Service or treatment provided and diagnosis.
- Provider's name, address, telephone number and tax ID number.

Mail the completed form to:

UnitedHealthcare  
Chevron Group No. 247848  
P.O. Box 30555  
Salt Lake City, UT 84130-0555

You should keep photocopies of each claim, so you can keep track of your reimbursements. The claims administrator may request additional information in order to process your claim.

If you have questions about a claim, wait at least 10 working days after you send in the claim form, and then call UnitedHealthcare at 1-800-654-0079. Or you can view your claim information on the website at [www.myuhc.com](http://www.myuhc.com). **Note:** You must be a registered member to use the myuhc.com website.

After you receive your *Explanation of Medicare Benefits* statement, you should file your claim as soon as you can to ensure timely payment. If you don't file a claim within six months (by June 30) following the year in which you incur a covered charge, no plan benefits will be payable for that covered charge.

### **UnitedHealthcare Explanation of Benefits**

After your claim has been processed, you will receive an *Explanation of Benefits (EOB)* statement. The *EOB* shows all the charges that were submitted, what charges the plan covered, and the amount that was actually paid. It also provides you with an explanation of how the benefit amounts were determined and the amount of payment, if any, you're responsible for paying.

### **Payment of Claims Incurred Outside the U.S.**

Claims incurred outside the U.S. and paid by the member in a foreign currency will be reimbursed using the "typical credit card rate plus 2 percent" as shown on [www.oanda.com](http://www.oanda.com) (a website used for currency conversion) for the date the service was incurred.

### **Initial Claim Review and Decision**

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

### **Types of Claims**

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

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

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

### **Time Limits for Processing Claims**

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

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

## Time Limits for Processing Claims

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

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

### **Concurrent Care Claims**

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

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

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

### **Notice and Payment of Claims**

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

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

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

## If Your Claim Is Denied

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

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

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

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

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

## How to File an Appeal

This section describes how to file an appeal and the time limits that apply to the different types of medical appeals.

<b>Time Limits for Processing Appeals</b>			
This chart describes the time limits for processing different types of appeals.			
<b>Time Limits</b>	<b>Types of Claims</b>		
	<b>Urgent Care Health Claims</b>	<b>Preservice Health Claims</b>	<b>Postservice Health Claims</b>
<b>Your deadline to file a first appeal</b>	<b>180 days</b> after receiving the claim denial notice.	<b>180 days</b> after receiving the claim denial notice.	<b>180 days</b> after receiving the claim denial notice.
<b>Plan notice of first appeal decision</b>	<b>Not later than 72 hours</b> after receiving an appeal.	<ol style="list-style-type: none"> <li><b>Not later than 15 days</b> after receiving an appeal, if the plan allows two levels of appeal.</li> <li><b>Not later than 30 days</b> after receiving an appeal, if the plan allows one level of appeal.</li> </ol>	<ol style="list-style-type: none"> <li><b>Not later than 30 days</b> after receiving an appeal, if the plan allows two levels of appeal.</li> <li><b>Not later than 60 days</b> after receiving an appeal, if the plan allows one level of appeal.</li> </ol>
<b>Your deadline to file a second appeal</b>	<b>N/A</b>	<b>90 days</b> after receiving the first appeal denial notice.	<b>90 days</b> after receiving the first appeal denial notice.
<b>Plan notice of second appeal decision</b>	<b>N/A</b>	<b>Not later than 15 days</b> after receiving a second appeal.	<b>Not later than 30 days</b> after receiving a second appeal.
<b>Your deadline to request an External Review</b>	<b>Four months</b> after receiving the appeal denial notice	<b>Four months</b> after receiving the second appeal denial notice	<b>Four months</b> after receiving the second appeal denial notice
<b>IRO notice of External Review Decision</b>	<b>Not later than 72 hours</b> after receiving the request for external review	<b>Not later than 45 days</b> after receiving the request for external review	<b>Not later than 45 days</b> after receiving the request for external review

## First Appeal

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

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

Your appeal should include *all* of the following:

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

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

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

### Where to Send Your First Appeal

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

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

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



### **Time Limits and Procedures for Processing Your First Appeal**

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

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

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

### **Notice of Decision on First Appeal**

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

If your first appeal is denied (in whole or in part), you will receive a written notice. The notice will contain information sufficient to identify the claim involved. The notice will state the reasons for the denial, including references to specific plan provisions upon which the denial was based and a statement of your right to file a civil lawsuit under Section 502(a) of ERISA following an adverse determination after completion of all levels of appeal/review required by the plan. The notice will state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

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

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

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

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

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

## Second Appeal

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

### Time Limits and Procedures for Processing Your Second Appeal

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

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

### Notice of Decision on Second Appeal

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

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

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

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

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

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

## Requesting an External Review

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

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

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

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

### Expedited External Review

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

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

To request an expedited external review, contact:

#### **UnitedHealthcare**

Phone: 1-800-654-0079

Fax: 1-813-818-3637

Email: Plan\_Sponsor\_Appeal\_Services@uhc.com

Mail: UnitedHealthcare

Attn Central Escalation Unit/Appeals | 601 Brooker Creek Rd | Oldsmar, FL 34677

## **Administrative Power and Responsibilities**

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

## If You're Covered by More Than One Health Plan

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Coordination of benefits is a feature used to determine how much the Chevron health plans pay when you or one of your dependents is also covered under another group health plan, including federal Medicare. This feature is designed to prevent overpayment of benefits.

**Note – there are independent Medicare plans that, as required by federal regulations, Chevron's Medicare Standard Plan cannot coordinate coverage with, for example Kelsey Seybold in Texas. You cannot be enrolled in Kelsey Seybold and also have coverage under a Chevron-sponsored Medicare plan.**

### How It Works

Under the coordination of benefits rules, one plan pays benefits first (the "primary payer") and one plan pays second (the "secondary payer"). (See below and the following pages for explanations of "primary payer" and "secondary payer".) The primary payer pays the benefits provided by its plan features. The secondary payer then pays any excess amounts required to bring the total benefits paid up to the levels payable under its plan. The sum of the benefits paid from each plan will not exceed the actual expense incurred. If the Chevron health plan is the secondary payer, the combined benefit from both plans won't be more than the Chevron plan's limit for the covered charges (except in some instances for the Chevron Medicare Plus Plan, the Chevron Senior Care Plan, the Chevron Dental PPO Plan, and the Prescription Drug Program). If the Chevron Dental PPO Plan is the secondary payer, plan benefits cannot be more than the negotiated fees or UCCI's allowance, but not to exceed your responsibility under the primary plan. Different coordination of benefits rules apply under different circumstances.

**For a information about coordination of benefits under the Prescription Drug Program refer to the Express Scripts Medicare™ (PDP) Evidence of Coverage document, mailed separately to you each year by Express Scripts. You also can call Express Scripts at 1-800-935-6215 to request a copy.**

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

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

A plan other than your Chevron health plan will be the primary payer if any of the following conditions applies to the other plan:

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

When you or a dependent is covered under both the Chevron Dental PPO Plan and a Chevron medical plan, the Dental PPO Plan will be the primary payer for services and supplies that are covered under both plans. If the Chevron medical plan is the secondary payer, the combined benefit from both plans won't total more than the Chevron plan's limit for the covered charges.

**Here's an example of how this works:**

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

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

## Coordinating Your Child's Coverage With Your Spouse's/Domestic Partner's Plan

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

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

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



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

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

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

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

## If You're Eligible for Medicare

**If you're enrolled in one of the Chevron Medical PPO Plans** and you or your dependent is eligible for federal Medicare, the Medicare-eligible person must be enrolled in the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, or the Chevron Senior Care Plan. In turn, Medicare becomes the primary payer for the Medicare-eligible person.

**Exception:** If you reside outside of the U.S. and you or your dependent is eligible for federal Medicare, the Medicare-eligible person will be enrolled in the Chevron Medical PPO Plan, and the Chevron Medical PPO Plan is the primary payer for services obtained outside of the U.S. However, in the event the Medicare-eligible person obtains services in the U.S., Medicare will be the primary payer. The Medicare-eligible person should enroll in both Part A and Part B since benefits will be calculated as though you are covered under Medicare Part A and Part B.

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

**If you're enrolled in the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, or the Chevron Senior Care Plan**, benefits payable under these plans are coordinated with benefits paid by federal Medicare. Part A and Part B of Medicare pay benefits first (the primary payer) and the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, or the Chevron Senior Care Plan pays benefits second (the secondary payer) for all charges covered under Medicare. See the earlier Chevron Medicare Plus Plan, Chevron Medicare Standard Plan, and Chevron Senior Care Plan sections for specific examples on how each plan coordinates with Medicare, as each plan coordinates with Medicare differently. Outpatient prescription drugs are covered under the Express Scripts Medicare™ (PDP), a Medicare-approved prescription drug plan. When you are enrolled in the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, or the Chevron Senior Care Plan, a few prescription drugs are also covered by Medicare Part B, such as some oral anticancer treatment drugs, immunosuppressive drugs, some diabetic supplies and some inhalation drugs. Those drugs covered by Medicare Part B also are covered by the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, and the Chevron Senior Care Plan. After Medicare benefits are paid, payments from the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, or the Chevron Senior Care Plan are coordinated with any other group insurance plan covering you or your dependents.

# Basic Vision Coverage

## Chevron Medicare Standard Plan

You and your eligible dependents have basic vision coverage under the Vision Program if you are enrolled in the Chevron Medicare Standard Plan. This program, administered by VSP, helps with the cost of eye exams.

## Highlights

### Basic Vision through VSP Vision Care (VSP)

Network	100% of the comprehensive eye exam, including dilation as needed, per calendar year.
Out-of-Network	Up to \$45 maximum reimbursement per calendar year for a comprehensive eye exam, including dilation as needed.

Discounts on eyeglasses, contact lenses and accessories are also available from VSP network providers.

## Evidence of Coverage Document

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

- VSP at 1-800-877-7195.
- Go to [www.vsp.com/go/chevron](http://www.vsp.com/go/chevron) on the Internet.

## How to Use Your Basic Vision Benefit

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

For the location of a network vision provider near you, to inquire about the cost to purchase lenses, frames or contact lenses or to locate a network provider for LASIK or PRK services, call VSP toll-free at 1-800-877-7195, Monday through Friday from 5 a.m. to 8 p.m. Pacific time, Saturday from 7 a.m. to 6 p.m. Pacific time, and Sunday 7 a.m. to 7 p.m. Pacific Time. You can also access the VSP website at [www.vsp.com/go/chevron](http://www.vsp.com/go/chevron).

## Basic Vision Claims

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

- VSP at 1-800-877-7195.
- Go to [www.vsp.com/go/chevron](http://www.vsp.com/go/chevron) on the Internet.

You must file a claim for payment of benefits no later than 365 days from the date the service was provided. If you don't file a proper claim with VSP within this timeframe, benefits for service will be denied. If your dispute concerns eligibility to participate in the plan, you must follow the procedures described in the How to File a Claim for Eligibility section in this book.

# Prescription Drugs

## Chevron Medicare Standard Plan

You and your eligible dependents are covered by the **Express Scripts Medicare™ (PDP)** if you are enrolled in the Chevron Medicare Standard Plan. For information about the prescription drug benefits available to you, review your **Express Scripts Medicare™ (PDP) Evidence of Coverage** document, mailed separately to you each year by Express Scripts. You also can call Express Scripts at 1-800-935-6215 to request a copy.



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# Chevron Senior Care Plan

This section describes the Medicare Standard Plan that Chevron offers to Medicare-eligible retirees. The plan covers a broad range of medical services when combined with benefits provided by federal Medicare. The plan includes prescription drug coverage under the Express Scripts Medicare™ (PDP), a Medicare-approved prescription drug plan administered by Express Scripts. The plan also includes a Vision Program administered by VSP.

**Note:** Medicare-eligible retirees also have the option of choosing the Chevron Medicare Plus Plan, the Medicare Standard Plan (described in other sections) or a Medicare HMO offered by the company (if available in your area).

- Medical Coverage – UnitedHealthcare (UHC)
- Basic Vision Coverage - VSP Vision Care (VSP)
- Prescription Drugs – Express Scripts

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**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.**



# Medical Coverage

## Chevron Senior Care Plan

The Chevron Senior Care Plan, hereafter referred to as the Senior Care Plan, is administered by UnitedHealthcare.

Depending on where you live, you may be eligible for a medical health maintenance organization (HMO) plan. If you choose an HMO for your medical coverage, you'll want to review the Medical and Dental HMO Supplement section.



## Overview of Benefits

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This summary is intended to provide you with an overview of the benefits available under the plan and is not intended to be all-inclusive. Please refer to each applicable section for more detailed information about these benefits. Important terms used below are defined later under How the Plan Works; they are important for determining the benefits available under the plan. The Chevron Senior Care Plan covers a portion of certain expenses not reimbursed by Medicare, including:

- 80 percent of Medicare's Part A (hospital) deductible.
- 80 percent of covered charges in an approved skilled nursing facility for the first 120 days per calendar year, less amounts paid by Medicare (Medicare covers the first 20 days, and the Chevron Senior Care Plan covers the 21st through 120th day of confinement).
- 80 percent of allowable charges for private-duty nursing care (out-of-hospital) for up to 1,600 hours each calendar year, if UnitedHealthcare's Personal Health Support is notified.
- A portion of outpatient prescription drugs, as described in the Express Scripts Medicare™ (PDP) Evidence of Coverage document.
- All or part of the cost of eye exams (depending on whether you choose a network or an out-of-network provider) as described in the Vision Program section.

In addition, once a covered individual meets his or her deductible/out-of-pocket maximum in a calendar year, the Chevron Senior Care Plan will pay 100 percent of covered charges for covered services for the remainder of the calendar year.

Service or Supply	What the Plan Pays
<b>Inpatient hospitalization</b>	<p><b>Part A Expenses</b>  80% of Medicare Part A deductible for days <b>1-60</b> then <b>100%</b> of covered charges after the deductible/out of pocket maximum per person of <b>\$2,500</b> has been met for days <b>61-150</b>. No benefit if beyond Medicare lifetime reserve days.</p> <p><b>Part B Expenses</b>  (which are generally the professional expenses)  100% of covered charges after \$2,500 deductible/out-of-pocket maximum per person is reached.</p>
<p><b>Other medical services</b></p> <ul style="list-style-type: none"> <li>• Blood</li> <li>• Ambulatory surgical center services</li> <li>• Medical supplies and equipment</li> <li>• Doctors' and therapists' care provided in a doctor's office, a hospital, or an outpatient facility</li> <li>• Cardiac rehabilitation therapy</li> <li>• Home health care</li> <li>• Hospice care</li> <li>• Ambulance transportation</li> <li>• Certain kinds of reconstructive cosmetic surgery</li> <li>• Dental care, if teeth are damaged or lost due to accidental injury, other than a chewing injury</li> <li>• Mental health care, inpatient treatment and outpatient visits</li> <li>• Inpatient and outpatient prescription drugs that are covered under Medicare Part B</li> <li>• Diabetic testing supplies</li> <li>• Prescription drugs filled on an emergency basis while traveling outside the U.S.</li> <li>• Second and third surgical opinions</li> <li>• Skilled nursing care (for the 21st through 100th day of confinement)</li> <li>• Certain nursing care services (\$10,000 maximum benefit per plan member per year) to receive benefits, patient must notify UHC Personal Health Support</li> </ul>	<p><b>100%</b> of covered charges after <b>\$2,500</b> deductible/out-of-pocket maximum per person is reached.</p>

## Inpatient Childbirth

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).

## How the Plan Works

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For certain services, the Chevron Senior Care Plan pays a portion of covered charges in excess of amounts Medicare pays. If you or your covered dependents are eligible for Medicare, you should enroll in both Part A and Part B since benefits under the Chevron Senior Care Plan will be calculated as though you are covered under Medicare Part A and Part B.

In addition, the plan covers a few services that are not covered by federal Medicare. (See When Charges Are Covered Only by the Chevron Senior Care Plan for an explanation of how benefits are calculated when care is covered only under the Chevron Senior Care Plan — and not by federal Medicare.)

The Chevron Senior Care Plan does not pay for most medical expenses until the \$2,500 per person annual deductible/out-of-pocket maximum is reached. For some types of expenses, you **don't** have to reach the deductible/out-of-pocket maximum before the plan pays benefits. If you haven't met the \$2,500 deductible/out-of-pocket maximum, the plan (together with any Medicare payments) pays 80 percent of your Medicare Part A deductible, as well as 80 percent of covered charges for certain private-duty nursing and skilled nursing facility care expenses. Once you reach the \$2,500 deductible/out-of-pocket maximum, the plan pays 100 percent of these expenses up to any specific benefit limits.

### Covered Charges

The amount of any benefit paid under this plan is determined based on the charges recognized by the plan. These recognized charges are called *covered charges*.

With the exception of prescription drugs and the Vision Program benefits, covered charges under the plan will be either the Medicare-approved amount or the allowable charge, depending on the situation.

Covered charges for the services and supplies covered by this plan and also covered by Medicare always will be based on the Medicare-approved amount. A service or supply covered under this plan must be used for the treatment of a non-occupational sickness or injury provided under the care or direction of a doctor.

**When the provider accepts Medicare assignment** of benefits, covered charges for any benefits payable under the Senior Care Plan, if any, will be based on the actual Medicare-approved amount.

**When the provider does not accept Medicare assignment** of benefits, covered charges for benefits payable under the Senior Care Plan, if any, will be based on the maximum amount Medicare permits providers to charge for covered services, currently 115 percent of the Medicare-approved amount.

Covered charges for all other services and supplies that are covered under the Chevron Senior Care Plan and not covered by Medicare, like private-duty nursing care, will always be based on the allowable charge.

### Incurred Expenses

Covered medical expenses that you or your dependents incur will be covered under this plan, provided coverage is in effect on the date you or your dependents incur the medical expense. Covered medical expenses are considered incurred on the date the service is rendered or on the date the product or supply is furnished.

The plan covers only services or supplies that are considered medically necessary (as defined below) for the diagnosis, treatment, or care of a sickness or injury. The plan doesn't pay for certain services, as explained under Expenses That Aren't Covered.

### **Medically Necessary**

This term generally refers to health care services and supplies that are determined by the claims administrator, in its sole discretion, to be medically appropriate and that are all of the following:

- Necessary to meet the basic health needs of the plan member or covered dependent.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the health care service or supply.
- Consistent in type, frequency and duration with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the claims administrator as to the type, frequency or duration of treatment.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the comfort or convenience of the patient, the patient's family, the doctor or another provider.
- Demonstrated through prevailing peer-reviewed medical literature to be either of the following:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed.
  - Safe, with promising efficacy for treating a life-threatening sickness or condition, provided in a clinically controlled research setting, and using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

For purposes of this definition, the term "life-threatening" is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment. The fact that a doctor has performed, prescribed, ordered, recommended or approved a procedure or treatment, or the fact that it may be the only treatment for a particular illness, injury or pregnancy doesn't mean that it's medically necessary and appropriate as defined here.

### **Therapeutic vs. Maintenance Care**

There may come a time in treatment — for example, in the case of chiropractic care and speech, physical, orthoptic and occupational therapies — when the care provided ceases to be "therapeutic" and instead is administered to "maintain" a level of functioning. Maintenance care does not satisfy the Chevron Senior Care Plan's definition of a covered health service and, therefore, is not covered under the plan.

## **Predetermination of Benefits**

If you're uncertain whether a service will be covered by the plan, in advance of treatment, you or your doctor should contact UnitedHealthcare at 1-800-654-0079. A representative will let you know what services are covered.

# Deductible/Out-of-Pocket Maximum

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There is a limit to the amount of covered charges you must pay out-of-pocket in any calendar year. The deductible/out-of-pocket maximum protects you from extreme financial loss in the event of catastrophic medical expenses.

After your deductible/out-of-pocket costs (as defined below) not paid by Medicare reach \$2,500 per person in a calendar year, the plan will pay 100 percent of most covered charges you incur during the remainder of that calendar year.

## What Applies to the Deductible/Out-of-Pocket Maximum

Your deductible/out-of-pocket expenses for the following covered charges are credited toward your \$2,500 deductible/out-of-pocket maximum:

- Your share of Medicare Part A inpatient hospital charges (other than the member's cost share for Medicare's Part A deductible), including blood.
- Your share of Medicare Part B outpatient hospital facility charges, including blood.
- Your share of all other Medicare Part B services, including doctors' charges and the member's cost share of the Medicare Part B deductible.
- Your share of radiation therapy, home IV therapy, chemotherapy, kidney dialysis, prosthetic appliances and durable medical equipment.

## What Does Not Apply to the Deductible/Out-of-Pocket Maximum

These expenses do not apply to your annual deductible/out-of-pocket maximum:

- The Medicare Part A deductible.
- Your share of the cost of medication purchased through the Express Scripts Medicare™ (PDP), including drug copayments, coinsurance amounts and deductibles.
- Your share of the cost for eyewear, exams, or other vision products purchased through the plan's Vision Program (as described later in this booklet).
- Out-of-pocket expenses for private-duty nursing and skilled nursing care.
- Expenses that are specifically excluded from the plan.
- Expenses above covered charges described in this plan.

## When Charges Are Covered by Both Federal Medicare and the Chevron Senior Care Plan

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When charges for health care are covered by both federal Medicare and the Chevron Senior Care Plan, benefits under the Chevron Senior Care Plan are based on Medicare-approved charges. The method for determining benefits depends on whether your health care provider accepts Medicare's "assignment" of approved charges.

When health care providers accept assignment, they agree to accept Medicare's guidelines of the approved charge for the services rendered (even if Medicare's approved charge is less than the actual charge).

When providers don't accept Medicare's approved charge for their services, there's a federal limit on the amount they can receive for their services. Under current law, the maximum amount they can receive is 115 percent of Medicare's approved charge.

### Medicare-Approved Amount (or Medicare-Approved Charge)

The Medicare-approved amount or charge is the charge on which Medicare bases its payment. In most cases, Medicare's approved amount will be less than the allowable charge.

Here are two examples that show how Chevron Senior Care Plan benefits are calculated when a provider accepts assignment — and when a provider doesn't accept assignment.

### When Your Health Care Provider Accepts Assignment

When your health care provider accepts assignment, the Medicare-approved amount is the maximum "covered charge" under the Chevron Senior Care Plan. The Chevron Senior Care Plan pays 100 percent of the portion of the covered charge that remains after Medicare's payment after you reach \$2,500 in deductible/out-of-pocket expenses. Here's an example:

Assume that a doctor's usual charge for a service is \$220 and the Medicare-approved amount for the service is \$200. Medicare pays 80 percent of the approved amount (after Medicare deductibles have been paid), or \$160 ( $\$200 \times 80\% = \$160$ ). We'll also assume you've met the deductible/out-of-pocket maximum; that is, your costs not covered by Medicare were **already more than \$2,500** for the year.

Here's how to calculate the Chevron Senior Care Plan benefit:

- **Step 1.** Subtract Medicare's payment from the Medicare-approved amount to determine the covered charge under the Chevron Senior Care Plan ( $\$200 - \$160 = \$40$ ).
- **Step 2.** Because you've already reached the \$2,500 deductible/out-of-pocket maximum, the Chevron Senior Care Plan's benefit is 100 percent of this covered charge, or \$40.

In this example, Medicare pays \$160 and the Chevron Senior Care Plan pays \$40, for a total of \$200 (the covered charge under the Chevron Senior Care Plan).

## When Your Health Care Provider Doesn't Accept Assignment

When your health care provider doesn't accept assignment, benefits under the Chevron Senior Care Plan are usually based on the federal limit on what providers can be paid for their services — 115 percent of the Medicare-approved amount (or the actual charge, if less). The Chevron Senior Care Plan pays 100 percent of the portion of the covered charge that remains after Medicare's payment after you reach \$2,500 in deductible/out-of-pocket expenses. Here's an example:

Assume that a doctor's actual charge for a service is \$220, that the Medicare-approved amount is \$200, and that Medicare pays 80 percent of this amount, or \$160 ( $\$200 \times 80\% = \$160$ ), after Medicare deductibles have been paid. Also assume that you've met the deductible/out-of-pocket maximum; that is, your costs not covered by Medicare were **already more than \$2,500** for the year.

Here's how to calculate the Chevron Senior Care Plan benefit:

- **Step 1.** Determine the "covered charge" under the Chevron Senior Care Plan as follows:
  - a. Multiply the Medicare-approved charge by 115 percent ( $\$200 \times 115\% = \$230$ ).
  - b. The lower amount — the result of 1a. or the doctor's actual charge — is the covered charge under the Chevron Senior Care Plan. (In this case, the lower amount is the doctor's actual charge of \$220.)
- **Step 2.** Subtract Medicare's payment from the covered charge under the Chevron Senior Care Plan ( $\$220 - \$160 = \$60$ ).
- **Step 3.** Because you've reached the \$2,500 deductible/out-of-pocket maximum, the Chevron Senior Care Plan's benefit is 100 percent of this covered charge, or \$60.

In this example, Medicare pays \$160 and the Chevron Senior Care Plan pays \$60, for a total of \$220 (the covered charge under the Chevron Senior Care Plan).

## When Charges Are Covered Only by the Chevron Senior Care Plan

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When charges are covered by the Chevron Senior Care Plan — but not by federal Medicare — the plan’s “allowable charge” limits apply. The plan’s claims administrator determines whether a charge is allowable, as explained below. If a charge is more than the allowable amount, the excess charges are not covered under the plan.

### **Allowable Charge**

Allowable charge means an amount measured and determined by the claims administrator by comparing the actual charge for a service or supply with the prevailing charges made for it. The claims administrator, in its sole discretion, determines the prevailing charge, taking into account pertinent factors including, but not limited to:

- The Medicare-approved amount for such service.
- The complexity of the service.
- The range of services provided.
- The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

Allowable charges for prescription drug and vision claims will be determined separately (if applicable) by the claims administrators of the Express Scripts Medicare™ (PDP) and the Vision Program.



# What the Plan Will Cover

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The following list of benefits is not all-inclusive. UnitedHealthcare may determine that other specific expenses are covered under the plan. If you have a question about a specific service, you should contact UnitedHealthcare.

## Private-Duty Nursing Care

Even though Medicare does not cover any charges incurred for private-duty nursing, the Chevron Senior Care Plan will pay up to 80 percent of allowable charges for the first 1,600 hours of private-duty nursing care in each calendar year, when ordered by a physician for noncustodial care. The 20 percent you pay does not count toward your annual Chevron Senior Care Plan deductible/out-of-pocket maximum. Prior to incurring private-duty nursing care, contact UnitedHealthcare's Personal Health Support to confirm that the proposed services are covered under the plan. Personal Health Support can be reached by calling 1-800-654-0079 on Monday through Friday between 7 a.m. and 5 p.m. Pacific time. Custodial care *is not* covered under the plan.

## Skilled Nursing Facility Care

Skilled nursing facility care is covered for room and board accommodations and other services and supplies for the first 120 days per calendar year at an approved facility. Medicare covers the first 20 days and the Chevron Senior Care Plan covers the 21st through the 120th day of confinement. The confinement must be necessary on account of the same or related condition as the hospital confinement, must be certified in writing, and must be supervised by a physician.

The plan will pay 80 percent of the facility's covered charge for a semiprivate room, less any benefits paid by Medicare. The 20 percent you pay does not count toward your annual Chevron Senior Care Plan deductible/out-of-pocket maximum. Contact UnitedHealthcare's Personal Health Support to find out whether a particular convalescent facility is approved by Medicare or meets UnitedHealthcare's definition of an approved facility. Personal Health Support can be reached by calling 1-800-654-0079 on Monday through Friday between 7 a.m. and 5 p.m. Pacific time.

## Reconstructive Surgery

After you reach the \$2,500 deductible/out-of-pocket maximum, the plan pays 100 percent of covered charges that remain after Medicare's payment for reconstructive cosmetic surgery required to repair a birth defect or damage caused by an accidental injury or disfiguring disease. 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.
- Protheses.
- Treatment remedies for physical complications during all stages of the mastectomy, including lymphedemas.

## **Vision Care**

If you're covered by one of the Chevron medical plans described in this booklet, you and your eligible dependents automatically are covered by the Vision Program. This plan, administered by VSP, helps with the cost of eye exams. For details, see the Vision Program section.

## **Non-U.S. Medical Services**

The plan will reimburse you for 100 percent of billed charges, after your deductible/out-of-pocket maximum has been reached, for emergency medical treatment and services incurred outside the U.S. and that are otherwise covered charges under the plan. This amount will be reduced by any amount payable under Medicare. Nonemergency medical services and travel expenses are not covered by the plan.

# Expenses That Aren't Covered Under the Chevron Senior Care Plan

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In addition to the limitations detailed in previous sections, there are other expenses not covered under this plan. The following list of benefit exclusions is not all-inclusive. UnitedHealthcare may determine that other specific expenses are not covered under the plan. If you have a question about a specific service, you should contact UnitedHealthcare. The Chevron Senior Care Plan does not cover the following:

- Services and supplies provided during times you or your covered dependents were not covered under this plan.
- Charges for services that aren't considered medically necessary.
- Hospice and home health care services not provided under the plan's private-duty and skilled nursing facility benefits.
- Services and supplies that do not meet the definition of medically necessary.
- Charges in excess of the "covered charges," as defined in the plan.
- Any type of therapy, service or supply, including, but not limited to, spinal manipulations by a chiropractor or other doctor for the treatment of a condition that ceases to be therapeutic treatment, as determined by UnitedHealthcare, and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
- Custodial care services that are all of the following:
  - Are non-health-related services, such as assistance in activities of daily living (including, but not limited to, feeding, dressing, bathing, transferring and ambulating).
  - Are health-related services that do not seek significant and objective improvement, or which are provided during periods when the medical condition of the patient who requires the service is not changing.
  - Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.
- Cosmetic surgery and treatment (surgery and treatment primarily to change appearances), whether or not for psychological or emotional reasons, including confinement, treatment, services and supplies, except reconstructive surgery that's covered by Medicare.
- Services provided by any person who is a member of your immediate family or who resides in your home.
- Hospital charges for a private room that are in excess of the hospital's regular daily rate for semiprivate room accommodations.
- Private-duty nursing services while confined in a hospital or other facility.

- Services given by a pastoral counselor.
- Eye refractions (vision screenings), eyeglasses, contact lenses and supplies, hearing aids, routine hearing tests, cochlear implants, or the fitting of any of these supplies (except eye care services as described under the Vision Program), unless required by an accidental injury that occurs while covered under this plan.
- Surgical procedures to correct refraction errors of the eyes (for example, LASIK or PRK), including any confinement, services or supplies given in connection with, or related to, the surgery.
- Services and supplies in connection with an occupational injury or sickness. An occupational injury or sickness is an injury or sickness that is covered under a workers' compensation act or similar law, or that is sustained while working for compensation, profit or gain. For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the workers' compensation act or similar law had that coverage been elected.
- Injury or other loss sustained as an active participant in war or any act of war, whether war is declared or not, international armed conflict, or conflict involving armed forces of any international authority.
- Treatment in a U.S. government or agency hospital. However, the reasonable cost incurred by the U.S. or one of its agencies for inpatient medical care and treatment given by a hospital of the uniformed services may be covered under the plan. The cost of this inpatient medical care and treatment will be covered if the charges for the care and treatment are otherwise covered under this plan, and the care and treatment were provided to any of the following:
  - A person retired from the uniformed services.
  - A family member of a person who is retired from the uniformed services.
  - A family member of a person who is active in the uniformed services.
  - A family member of a deceased member of the uniformed services.
- Expenses that you, yourself, are not legally required to pay. However, the reasonable cost incurred by the U.S. for medical care and treatment given to a veteran by the U.S. or one of its agencies may be covered under this plan. The cost of the care and treatment will be covered if:
  - The veteran does not have a service-related disability. and
  - Charges for the care and treatment are otherwise covered under the plan.
- Education, training, and bed and board in an institution that is primarily a school, or another institution for training or a place of rest, or a domicile for the aged.
- Sensitivity training or educational training therapy or treatment for an education requirement.

- Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or for permanent loss of hair from an accidental injury), hair transplants, hair weaving, or any drug, if the drug is used in connection with baldness.
- Treatment considered experimental, unproven, or investigative, because it does not meet generally accepted standards of medical practice in the U.S. This includes any related confinement, treatment, service or supply.
- Confinement, treatment, services and supplies given for or related to any of the following:
  - Abdominoplasty.
  - Sex-change surgery.
  - Reversal of sterilization.
  - Nutritional counseling in a group setting.
  - Liposuction.
  - Speech therapy for fluency disorders.
  - Tobacco dependency.
  - Massage therapy, including, but not limited to, Rolfing and acupuncture.
  - Health club membership costs, purchases of home whirlpools, spas and saunas for any reason.
  - Tine test for tuberculosis.
  - Charges for completion of claims, missed appointments, telephone conversations or consultations, Internet visits of any type, and standby services required by a physician.
  - Herbal medicine and holistic or homeopathic care, including, but not limited to, drugs, aromatherapy, and ecological or environmental medicine.
- Personal convenience or comfort items or general household goods, including, but not limited to, purchase or rental of radios, TVs, telephones, first-aid kits, exercise equipment, air conditioners, food, liquefiers, cost of meals for guests, newspapers, humidifiers, or bedside service tables.
- Benefits for durable medical equipment if repaired and/or replaced more than once every three years. benefits for prosthetic devices if purchased more than once every three years.
- Weight reduction and control, unless accompanied by a diagnosis of severe or morbid obesity. membership costs for weight-loss clinics and similar programs and special foods, food supplements, liquid diets, diet plans, or other related products.
- Examinations and treatment ordered by a court in connection with legal proceedings, unless such examinations and treatment otherwise qualify as covered expenses.
- Charges that are payable under the federal Medicare program.
- Charges that aren't covered by the federal Medicare program, unless specified in this plan.

- Charges that exceed Medicare-approved amounts, if they're covered by Medicare.
- Nonrehabilitative education care.
- Charges for which a claim for benefits isn't filed within six months (by June 30) following the year in which the covered charge is incurred.
- Treatment or services that aren't prescribed as medically necessary by a doctor (although not all services or treatments prescribed by a doctor are considered covered charges).
- Any drugs, unless provided while confined in a hospital or unless they are injectable drugs that are routinely or customarily administered by a doctor or registered nurse (R.N.) in the provider's office.
- Experimental procedures, drugs or devices not considered safe and effective (as determined by the claims administrator).
- In vitro fertilization and related services.
- Transportation, other than ambulance services specifically covered by Medicare.
- Dental care, other than dental care specifically covered by Medicare.
- Auxiliary items normally available without a prescription, even though they're recommended by a doctor (including items such as posture chairs, hot tubs, exercise bicycles, and other exercise equipment).
- Routine physical exams or checkups, including X-rays and lab tests for such examinations, immunizations, and blood tests required for a marriage license, other than preventive care specifically covered by Medicare.
- Payments for which you are reimbursed or are eligible to receive reimbursement as a result of any award or settlement from a third party for medical expenses resulting from an act or failure to act of the third party — including reimbursements under no-fault automobile insurance — unless you or your dependent agrees to reimburse the plan when damages are recovered from the third party.
- Treatment of an injury that results from your active participation in an insurrection, a crime, a riot, or an unlawful act.
- Immunizations for travel outside the U.S. or for occupational requirements.
- Charges for preventive care, other than preventive care specifically covered by Medicare.
- Charges for private-duty nursing care that isn't preapproved by UnitedHealthcare's Personal Health Support.
- Care in a skilled nursing facility for the first 20 days or beyond 120 days in a calendar year.

# Medical Claims and Appeals

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This section describes how to file a claim for Chevron Senior Care Plan benefits and the claim review and appeals process that is followed whenever you submit a claim for benefits. You should be aware that UnitedHealthcare has the right to request repayment if they overpay a claim for any reason. **Note:** This information pertains to medical claims only. For information about filing vision claims, see the Vision section. For information about filing a prescription drug claim, see the Prescription Drug section. 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

When you have expenses covered under Medicare, your provider generally files a claim with Medicare and then with UnitedHealthcare, who is the claims administrator for the Chevron Senior Care Plan.

You should file your medical claims as you incur a covered charge, even if you haven't satisfied the plan's deductible requirement. You must submit a request for payment of benefits within six months (by June 30) following the year of the service. If you don't provide this information to the claims administrator within six months following the year of the service, benefits for that health service will be denied, according to the plan or otherwise at the claims administrator's discretion. This time limit does not apply if you are legally incapacitated. Also, this time limit doesn't apply if Medicare has not yet processed your claim. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

### Filing a Claim With Medicare

In most cases, providers under Part A and Part B, such as hospitals and physicians, submit claims to Medicare for you. You then receive an *Explanation of Medicare Benefits* that you can send to UnitedHealthcare with your claim for Chevron Senior Care Plan benefits. Under the Chevron Senior Care Plan, you rarely will need to file claims for Medicare Part A services. In general, your Medicare Part A benefits will be filed for you by the hospital as a Medicare assigned claim. Medicare Part B expenses are not eligible for reimbursement under the Chevron Senior Care Plan, unless you reach your deductible/out-of-pocket maximum by incurring \$2,500 in deductible/out-of-pocket costs in a calendar year. You should file your medical claims as you obtain services so that charges are being applied against your deductible/out-of-pocket maximum throughout the year.

### Filing a Claim With UHC: Medicare Crossover Program

To simplify the way you file claims for Medicare Part A and Part B expenses, UnitedHealthcare offers the Medicare Crossover program. Under this program, you or your provider sends a claim to Medicare for Part A and Part B benefits. Medicare will automatically send a copy of your *Explanation of Medicare Benefits* statement electronically to UnitedHealthcare. UnitedHealthcare then processes the remainder of the claim.

### **Filing a Claim With UHC: Claim Forms**

When submitting a claim form for expenses covered under the Chevron Senior Care Plan *but not covered under Medicare*, such as for private-duty nursing benefits, you must submit a claim form. Also, if you use a provider who does not accept Medicare, you will need to submit a claim form. You should attach all itemized bills for medical expenses when submitting a claim form for expenses covered under the Chevron Senior Care Plan. There are several ways to obtain a claim form:

- Call UnitedHealthcare, the plan's claims administrator, at 1-800-654-0079.
- Access UnitedHealthcare's website at [www.myuhc.com](http://www.myuhc.com).
- Access the Benefits Connection website at [www.benefitsweb.com/chevron.html](http://www.benefitsweb.com/chevron.html).
- Call the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).

When you fill out the claim form, use your full name and include your subscriber number (which can be found on your UnitedHealthcare ID card). Attach all the bills and receipts you received for the services and supplies provided, as well as the Explanation of Medicare Benefits statement for a Part A covered expense. On your itemized bill, be sure to include all of the following:

- Your (the retired employee's) UnitedHealthcare subscriber number (found on your UnitedHealthcare ID card).
- Name of patient (if the patient is a dependent) and, if applicable, name of the retired employee.
- Date of service.
- "Chevron Group No. 247848" printed on the face of the statement.
- Amount of charge.
- Service or treatment provided and diagnosis.
- Provider's name, address, telephone number and tax ID number.
- Name of patient (if the patient is a dependent) and, if applicable, name of retired employee.
- Date of service.
- Your (the retired employee's) Social Security number or UnitedHealthcare's subscriber number.
- "Chevron Group No. 247848" printed on the face of the statement.
- Amount of charge.
- Service or treatment provided and diagnosis.
- The provider's name, address, telephone number and tax identification number.



Mail the completed form to:

UnitedHealthcare  
Chevron Group No. 247848  
P.O. Box 30555  
Salt Lake City, UT 84130-0555

Medicare Part B expenses are covered under the plan only after you have met your deductible/out-of-pocket maximum for the calendar year (see What Applies to the Deductible/Out-of-Pocket Maximum earlier in this section).

You should keep photocopies of each claim, so you can keep track of your reimbursements. The claims administrator may request additional information in order to process your claim. If you have questions about a claim, wait at least 10 working days after you send in the claim form and then call UnitedHealthcare at 1-800-654-0079. Or you can view your claim information on the website at [www.myuhc.com](http://www.myuhc.com). **Note:** You must be a registered member to use the myuhc.com website.

After you receive your Explanation of Medicare Benefits statement, you should file your claim as soon as you can to ensure timely payment. If you don't file a claim within six months (by June 30) following the year in which you incur a covered charge, no plan benefits will be payable for that covered charge.

#### **UnitedHealthcare Explanation of Benefits**

After your claim has been processed, you will receive an *Explanation of Benefits (EOB)* statement. The *EOB* shows all the charges that were submitted, what charges the plan covered, and the amount that was actually paid. It also provides you with an explanation of how the benefit amounts were determined and the amount of payment, if any, you're responsible for paying.

#### **Payment of Claims Incurred Outside the U.S.**

Claims for emergency services incurred outside the U.S. and paid by the member in a foreign currency will be reimbursed using the "typical credit card rate plus 2 percent" as shown at [www.oanda.com](http://www.oanda.com) (a website used for currency conversion) for the date the service was incurred.

## Initial Claim Review and Decision

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

### Types of Claims

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

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

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

### Time Limits for Processing Claims

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

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

## Time Limits for Processing Claims

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

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

### **Concurrent Care Claims**

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

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

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

### **Notice and Payment of Claims**

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

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

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

## If Your Claim Is Denied

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

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

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

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

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

## How to File an Appeal

This section describes how to file an appeal and the time limits that apply to the different types of medical appeals.

<b>Time Limits for Processing Appeals</b>			
This chart describes the time limits for processing different types of appeals.			
Time Limits	Types of Claims		
	Urgent Care Health Claims	Preservice Health Claims	Postservice Health Claims
<b>Your deadline to file a first appeal</b>	<b>180 days</b> after receiving the claim denial notice.	<b>180 days</b> after receiving the claim denial notice.	<b>180 days</b> after receiving the claim denial notice.
<b>Plan notice of first appeal decision</b>	<b>Not later than 72 hours</b> after receiving an appeal.	<ol style="list-style-type: none"> <li><b>Not later than 15 days</b> after receiving an appeal, if the plan allows two levels of appeal.</li> <li><b>Not later than 30 days</b> after receiving an appeal, if the plan allows one level of appeal.</li> </ol>	<ol style="list-style-type: none"> <li><b>Not later than 30 days</b> after receiving an appeal, if the plan allows two levels of appeal.</li> <li><b>Not later than 60 days</b> after receiving an appeal, if the plan allows one level of appeal.</li> </ol>
<b>Your deadline to file a second appeal</b>	<b>N/A</b>	<b>90 days</b> after receiving the first appeal denial notice.	<b>90 days</b> after receiving the first appeal denial notice.
<b>Plan notice of second appeal decision</b>	<b>N/A</b>	<b>Not later than 15 days</b> after receiving a second appeal.	<b>Not later than 30 days</b> after receiving a second appeal.
<b>Your deadline to request an External Review</b>	<b>Four months</b> after receiving the appeal denial notice	<b>Four months</b> after receiving the second appeal denial notice	<b>Four months</b> after receiving the second appeal denial notice
<b>IRO notice of External Review Decision</b>	<b>Not later than 72 hours</b> after receiving the request for external review	<b>Not later than 45 days</b> after receiving the request for external review	<b>Not later than 45 days</b> after receiving the request for external review

## First Appeal

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

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

Your appeal should include *all* of the following:

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

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

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

### Where to Send Your First Appeal

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

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

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

### **Time Limits and Procedures for Processing Your First Appeal**

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

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

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

### **Notice of Decision on First Appeal**

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

If your first appeal is denied (in whole or in part), you will receive a written notice. The notice will contain information sufficient to identify the claim involved. The notice will state the reasons for the denial, including references to specific plan provisions upon which the denial was based and a statement of your right to file a civil lawsuit under Section 502(a) of ERISA following an adverse determination after completion of all levels of appeal/review required by the plan. The notice will state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.



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

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

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

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

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

## **Second Appeal**

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

### **Time Limits and Procedures for Processing Your Second Appeal**

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

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

### **Notice of Decision on Second Appeal**

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

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

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

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

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

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

### **Requesting an External Review**

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

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

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

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

### **Expedited External Review**

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

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

To request an expedited external review, contact:

#### **UnitedHealthcare**

Phone: 1-800-654-0079

Fax: 1-813-818-3637

Email: [Plan\\_Sponsor\\_Appeal\\_Services@uhc.com](mailto:Plan_Sponsor_Appeal_Services@uhc.com)

Mail: UnitedHealthcare

Attn Central Escalation Unit/Appeals | 601 Brooker Creek Rd | Oldsmar, FL 34677

## **Administrative Power and Responsibilities**

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

## If You're Covered by More Than One Health Plan

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Coordination of benefits is a feature used to determine how much the Chevron health plans pay when you or one of your dependents is also covered under another group health plan, including federal Medicare. This feature is designed to prevent overpayment of benefits.

**Note – there are independent Medicare plans that, as required by federal regulations, Chevron's Senior Care Plan cannot coordinate coverage with, for example Kelsey Seybold in Texas. You cannot be enrolled in Kelsey Seybold and also have coverage under a Chevron-sponsored Medicare plan.**

### How It Works

Under the coordination of benefits rules, one plan pays benefits first (the "primary payer") and one plan pays second (the "secondary payer"). (See below and the following pages for explanations of "primary payer" and "second payer".) The primary payer pays the benefits provided by its plan features. The secondary payer then pays any excess amounts required to bring the total benefits paid up to the levels payable under its plan. The sum of the benefits paid from each plan will not exceed the actual expense incurred. If the Chevron health plan is the secondary payer, the combined benefit from both plans won't be more than the Chevron plan's limit for the covered charges (except in some instances for the Chevron Medicare Plus Plan, the Chevron Senior Care Plan, the Chevron Dental PPO Plan, and the Prescription Drug Program). If the Chevron Dental PPO Plan is the secondary payer, plan benefits cannot be more than the negotiated fees or UCCI's allowance, but not to exceed your responsibility under the primary plan. Different coordination of benefits rules apply under different circumstances.

For information about coordination of benefits under the Prescription Drug Program refer to the Express Scripts Medicare™ (PDP) *Evidence of Coverage* document, mailed separately to you each year by Express Scripts. You also can call Express Scripts at 1-800-935-6215 to request a copy.

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

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

A plan other than your Chevron health plan will be the primary payer if any of the following conditions applies to the other plan:

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

When you or a dependent is covered under both the Chevron Dental PPO Plan and a Chevron medical plan, the Dental PPO Plan will be the primary payer for services and supplies that are covered under both plans. If the Chevron medical plan is the secondary payer, the combined benefit from both plans won't total more than the Chevron plan's limit for the covered charges.

**Here's an example of how this works:**

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

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

## **Coordinating Your Child's Coverage With Your Spouse's/Domestic Partner's Plan**

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

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

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

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

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

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

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

## If You're Eligible for Medicare

**If you're enrolled in one of the Chevron Medical PPO Plans** and you or your dependent is eligible for federal Medicare, the Medicare-eligible person must be enrolled in the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, or the Chevron Senior Care Plan. In turn, Medicare becomes the primary payer for the Medicare-eligible person.

**Exception:** If you reside outside of the U.S. and you or your dependent is eligible for federal Medicare, the Medicare-eligible person will be enrolled in the Chevron Medical PPO Plan, and the Chevron Medical PPO Plan is the primary payer for services obtained outside of the U.S. However, in the event the Medicare-eligible person obtains services in the U.S., Medicare will be the primary payer. The Medicare-eligible person should enroll in both Part A and Part B since benefits will be calculated as though you are covered under Medicare Part A and Part B.

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

**If you're enrolled in the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, or the Chevron Senior Care Plan,** benefits payable under these plans are coordinated with benefits paid by federal Medicare. Parts A and B of Medicare pay benefits first (the primary payer) and the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, or the Chevron Senior Care Plan pays benefits second (the secondary payer) for all charges covered under Medicare. See the earlier Chevron Medicare Plus Plan, Chevron Medicare Standard Plan, and Chevron Senior Care Plan sections for specific examples on how each plan coordinates with Medicare, as each plan coordinates with Medicare differently. Outpatient prescription drugs are covered under the Express Scripts Medicare™ (PDP), a Medicare-approved prescription drug plan. When you are enrolled in the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, or the Chevron Senior Care Plan, a few prescription drugs are also covered by Medicare Part B, such as some oral anticancer treatment drugs, immunosuppressive drugs, some diabetic supplies and some inhalation drugs. Those drugs covered by Medicare Part B also are covered by the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, and the Chevron Senior Care Plan. After Medicare benefits are paid, payments from the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, or the Chevron Senior Care Plan are coordinated with any other group insurance plan covering you or your dependents.



# Basic Vision Coverage

## Chevron Senior Care Plan

You and your eligible dependents have basic vision coverage under the Vision Program if you are enrolled in the Chevron Senior Care Plan. This program, administered by VSP, helps with the cost of eye exams.



## Highlights

### Basic Vision through VSP Vision Care (VSP)

Network	100% of the comprehensive eye exam, including dilation as needed, per calendar year.
Out-of-Network	Up to \$45 maximum reimbursement per calendar year for a comprehensive eye exam, including dilation as needed.

Discounts on eyeglasses, contact lenses and accessories are also available from VSP network providers only.

### Evidence of Coverage Document

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

- VSP at 1-800-877-7195.
- Go to [www.vsp.com/go/chevron](http://www.vsp.com/go/chevron) on the Internet.

### How to Use Your Basic Vision Benefit

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

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

### Basic Vision Claims

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

- VSP at 1-800-877-7195.
- Go to [www.vsp.com/go/chevron](http://www.vsp.com/go/chevron) on the Internet.

You must file a claim for payment of benefits no later than 365 days from the date the service was provided. If you don't file a proper claim with VSP within this timeframe, benefits for service will be denied. If your dispute concerns eligibility to participate in the plan, you must follow the procedures described in the How to File a Claim for Eligibility section in this book.

# Prescription Drugs

## Chevron Senior Care Plan

You and your eligible dependents are covered by the **Express Scripts Medicare™ (PDP)** if you are enrolled in the Chevron Senior Care Plan. For information about the prescription drug benefits available to you, review your **Express Scripts Medicare™ (PDP) Evidence of Coverage** document, mailed separately to you each year by Express Scripts. You also can call Express Scripts at 1-800-935-6215 to request a copy.



# Dental PPO Plan

The Chevron Dental Plan (also referred to as the Dental PPO) is designed to help you pay for diagnostic, preventive, basic restorative and major dental care, up to certain benefit maximums. United Concordia Companies, Inc. (UCCI) is the claims administrator for this plan.

- United Concordia Companies, Inc. (UCCI)
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**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.**

# Overview

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- The Dental PPO Plan is a preferred provider organization (PPO) made up of more than 93,300 general dentists and specialists at more than 244,900 locations who have agreed to provide dental care at discounted fees. To get a list of PPO network providers near you, call United Concordia Companies, Inc. (UCCI) at 1-877-424-3876 or visit their website at [www.ucci.com](http://www.ucci.com). You can go to any dentist you choose for needed care. If you go to a dentist who participates in UCCI's Chevron Dental Network, you qualify for network coverage.
- If you see a network dentist or specialist, benefits are based on the discounted fees that UCCI's PPO dentists agree to charge; you pay coinsurance for most kinds of care, but there are no deductible requirements.
- If you choose to go to a dentist who is out-of-network, you qualify for out-of-network coverage. When you see a provider who is out-of-network, you must pay the required deductibles before plan benefits can be paid for basic and major dental care, and you're required to pay the difference between your dentist's charge and UCCI's allowance.
- Every calendar year, you and each enrolled family member can qualify for up to \$2,000 in network coverage benefits or up to \$1,500 in out-of-network coverage benefits.
- In addition, for orthodontic care for plan members, the plan can pay up to a lifetime maximum of \$1,500 in network benefits and \$1,000 in out-of-network benefits, with no deductible requirement.
- Similarly, for TMJ care for plan members, the plan can pay up to a lifetime maximum of \$750 for network and out-of-network benefits.
- If you were eligible for dental coverage when you retired, you and your eligible dependents were automatically enrolled in the dental plan you had as an employee unless you chose to cancel or change your coverage. If you have more than one dental plan available in your area, you may change your dental plan coverage during the open enrollment. If you relocate outside the service area for your current plan, you have 31 days to make a change to your coverage. Otherwise, you will have to wait until the next open enrollment to make a plan change.

**Dental coverage is not available to former Gulf, former Texaco, former Getty, former Caltex, or former Amoseas employees who retired before July 1, 2002, or to former Unocal employees who retired before July 1, 2006, or to their survivors.**

- The company currently pays part of the cost of this coverage. (In the Eligibility and Participation section, see Paying for Coverage for an explanation of how you pay your share of the cost of coverage.)

## Note

Depending on where you live, you may be eligible for a dental health maintenance organization (DHMO) plan. If you choose a DHMO for your dental coverage, you'll want to review the HMO or DHMO Supplement. This supplement gives you information about eligibility, participation and your legal rights. For information about covered services or for a list of DHMO providers, contact your DHMO.

## How the Plan Works

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The plan provides two levels of coverage for dental care:

- **Network coverage:** Applies when you receive dental care from a provider who participates in the plan's preferred provider organization (PPO), the UCCI Chevron Dental Network. To get a list of PPO network providers near you, call UCCI at 1-877-424-3876 or visit their website at [www.ucci.com](http://www.ucci.com). You don't have to pay a deductible when you receive care from a network provider, and you don't have to file claim forms. You'll pay your dentist the required coinsurance, if any.
- **Out-of-network coverage:** Applies when you choose to receive care from a dentist who doesn't participate in UCCI's Chevron Dental Network. If you use an out-of-network provider, you must satisfy a deductible for certain types of care, and you have to file claim forms to receive reimbursement for covered expenses.

You and your enrolled dependents decide whether to go to a network dentist — or an out-of-network dentist — each time you need dental care. This decision determines whether the care you receive qualifies for network coverage or out-of-network coverage. Your out-of-pocket expenses will generally be lower when you receive services from a network provider than for the same services received from an out-of-network provider.

There are benefit maximums under both network and out-of-network coverage.

**Note:** If you or your enrolled dependents reach a benefit maximum when using network providers, then the participating provider can charge his or her normal fee for future services. In this case, the provider is not bound by the negotiated fee schedule.

### Negotiated Fee(s)

The amount(s) a participating provider agrees to as payment in full for covered services. Negotiated fees are the fees agreed to by UCCI and the providers and are discounted to be usually lower than the provider's normal charge. The negotiated fee is the basis for plan reimbursement while receiving network benefits.

### Note

Since payable out-of-network benefits are based on UCCI's allowance, you may have to pay a portion of charges for diagnostic and preventive care.

### UCCI Companies, Inc.

UCCI is the claims administrator for the Dental PPO Plan. This organization manages the plan's preferred provider organization and reviews, approves, denies and processes claims filed by you or your provider. You can call UCCI at 1-877-424-3876. UCCI also sponsors the Concordia Plus dental HMO option available to eligible Chevron retirees who live in the plan's service area.

# Deductibles

If you choose to go to an out-of-network provider, you must pay required deductibles before plan benefits can be paid for basic and major dental care. You're also required to pay any difference between your dentist's charge and the plan's reimbursement, which is based on the allowance established by United Concordia UCCI.

No deductible is required for preventive and diagnostic care, orthodontic care, or non-surgical TMJ services.

Annual Deductible for Basic and Major Dental Care	Network	Out-of-Network
You Only	\$0	\$100
You and One Adult	\$0	\$200
You and Child(ren)	\$0	\$200
You and Family	\$0	\$300

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

For example, if you choose the "You and Family" coverage tier for Option 1, your annual deductible is satisfied when the family's accumulation of deductibles reaches \$300, with no more than \$100 applied for each family member. Your family could meet the \$300 deductible with charges of \$100 for one member, \$100 for a second member, \$50 for a third member and \$50 for a fourth member.

## UCCI's Allowance

For out-of-network providers, UCCI's allowance may vary from one geographic area to another. It is based on a range of rates and fees that most dentists and specialists charge for the same service in that area, and must be no more than the out-of-network provider normally charges for the service or supply. When reviewing charges to determine if they're covered under the plan's out-of-network coverage, United Concordia doesn't attempt to set the amount that nonparticipating dentists and other providers charge for needed services, nor do they restrict your right to go to any dentist you choose. However, United Concordia does determine UCCI's allowance, and you're responsible for paying the difference between your nonparticipating dentist's charge and the allowance established by United Concordia.

**Medically Necessary**

This term generally refers to services and supplies that are prescribed by a dentist or doctor and accepted by the health care community as being reasonable and necessary for treatment of the condition. Medically necessary services can include those that are appropriate and necessary to diagnose, treat and care for a dental condition.

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

**Covered Charges**

Charges that the plan pays for medically necessary services and supplies that are ordered by and while under the care and direction of a dentist or a doctor (although not all treatment or services prescribed by a dentist or a doctor are considered covered charges) and that are covered by the plan.

Network covered charges for those services and supplies are limited to negotiated fees between UCCI and the providers.

Out-of-network covered charges for those services and supplies are limited to UCCI's allowance for dental treatment that's either provided by a dentist or doctor or provided under the direction of a dentist or doctor.

**Dentist or Doctor**

The plan can help pay for services performed by a dentist (D.M.D. or D.D.S.) or doctor who is licensed by the governmental authority having jurisdiction over licensing in the locality of the dentist's or doctor's practice. The plan also covers services of a dental hygienist, a person who is licensed by the state and working under a dentist's supervision.



## Benefit Maximums

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Every calendar year, you and each enrolled family member can qualify for up to \$2,000 in network coverage benefits or up to \$1,500 in out-of-network coverage benefits.

In addition, for orthodontic care for plan members, the plan can pay up to a lifetime maximum of \$1,500 in network benefits and \$1,000 in out-of-network benefits, with no deductible requirement. These benefits are not counted when determining if the plan's annual maximums have been reached.

Nonsurgical treatment of temporomandibular joint dysfunction (TMJ) has a lifetime benefit maximum of \$750 for each plan member. These benefits aren't counted when determining if the plan's deductibles or annual maximums have been reached.

**Important:** Any network benefits you use count toward your annual maximum and/or lifetime maximums for out-of-network benefits. Similarly, any out-of-network benefits you use count toward your annual and/or lifetime maximum for network benefits. For example, if a plan member has received \$1,000 in benefits under network coverage and \$500 under out-of-network coverage, no further out-of-network benefits are payable for that individual, because the \$1,500 annual benefit maximum has been reached. However, that individual could qualify for another \$500 in benefits under network coverage — bringing total paid benefits up to the \$2,000 annual network coverage benefit maximum. This same principle applies to the Lifetime Maximum for Orthodontics and TMJ related services.

**Note:** If you or your enrolled dependents reach a benefit maximum when using network providers, then the participating provider can charge his or her normal fee for future services. In this case, the provider is not bound by the negotiated fees between UCCI and the provider.

# What the Plan Pays

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Network coverage and out-of-network coverage help pay for the following kinds of care:

- Diagnostic and preventive care.
- Basic dental care.
- Major dental care, including implants.
- TMJ Services (non-surgical).
- Orthodontic care.

You have to satisfy the plan's deductible requirements before the plan pays out-of-network benefits for some kinds of care.

## Diagnostic and Preventive Care

To encourage you and your dependents to take good care of your teeth, the plan can pay 100 percent of covered charges for routine diagnostic and preventive care, such as checkups and cleanings.

- **Network coverage:** Pays 100 percent of the negotiated fees with no deductible.
- **Out-of-network coverage:** Pays 100 percent of UCCI's allowance with no deductible. (You pay the difference between your dentist's fees and UCCI's allowance.)

These benefits are subject to the plan's annual benefit maximums.

The following services and supplies are covered for each enrolled member of your family:

- Two oral examinations per calendar year.
- Cleaning and scaling of teeth (called prophylaxis) performed by a dentist or dental hygienist twice per calendar year (an additional dental cleaning will be covered for pregnant women).
- Periodontal cleanings twice per calendar year following active periodontal therapy, in addition to cleaning and scaling of teeth (prophylaxis).
- Bitewing X-rays twice per calendar year.
- Full-mouth or panoramic X-rays once every 36 months.
- One sealant treatment of the permanent posterior teeth every 36 months for each covered child under age 14.
- Two fluoride treatments per calendar year for each plan member under age 19.

- Space maintainers, and required adjustments to them, for plan members under age 19 (if medically necessary due to premature loss or extraction of teeth, and necessary to prevent adjacent or opposing teeth from moving).
- Emergency treatment to relieve dental pain, including charges for X-rays (other kinds of care provided on the same day will be paid according to the plan's basic, major and orthodontic care coverages)

## Basic Dental Care

- **Network coverage:** Pays 90 percent of the negotiated fees with no deductible.
- **Out-of-network coverage:** Pays 80 percent of UCCI's allowance after you pay the deductible. (You pay the difference between your dentist's fees and UCCI's allowance.)

Covered basic dental care includes the following:

- **Fillings:** Amalgam, silicate, acrylic, synthetic, porcelain and composite fillings (anterior teeth only) to repair teeth that are broken or decayed. Coverage for composite fillings in posterior teeth is limited to the covered amount for amalgam fillings. Gold fillings are covered under major dental care. Replacement of restorative services only when they are not, and cannot be made serviceable, including:
  - Basic restorations (not within twelve (12) months of previous placement).
- **Oral surgery:** Tooth extractions, treatment of a fractured or dislocated jaw, cutting procedures (including removal of stitches and postoperative examinations), and the medically necessary anesthesia when performed by a dentist or an oral surgeon in his or her office, including when prescribed as part of an orthodontic treatment plan.
 

**Note:** When oral surgery is performed in a facility other than the oral surgeon's office, the oral surgeon's fees will be covered, but the facility and anesthesia charges will be excluded. Coordinate with your medical plan for facility and anesthesia coverage.
- **Periodontics:** Treatment of the gums (including scaling and root planing) and supporting tissue.
  - Scaling and root planing – not within 24 months of previous treatment.
  - Periodontal surgery – not within 24 months of previous surgery.
- **Endodontics:** Root canal therapy and other treatments related to dental pulp as follows:
  - Root canal re-treatment – one per tooth per lifetime.
  - Pulpal therapy – one per eligible tooth per lifetime. Eligible teeth limited to primary anterior teeth under age six and primary posterior molars under age twelve.
- **Antibiotic injections:** Injectable antibiotics only.

- **Crowns and inlays:** Adjustments and recementing of crowns and inlays more than twelve months after initial installation. (Initial installation of crowns and inlays is covered under major dental care.) Recementation allowed once per twelve months. Recementation during the first 12 months following insertion of the crown or bridge by the same dentist is included in the cost of the initial crown or bridge when services are received by a network provider. Crown repairs are also covered under this category.
- **Bridgework and dentures:** Repairs, adjustments and recementing of bridgework or dentures, relining or rebasing of dentures and charges for adding teeth to existing dentures, if needed to replace teeth while covered under the plan. Adjustments, relining or rebasing done within six months after initial installation aren't covered under the basic dental care. (Initial installation of bridgework and dentures and the first six months of their maintenance are covered under major dental care.)
- **Second opinions:** Covered if provided by an independent consulting dentist.
- **Lab tests and reports:** The plan covers lab tests and reports necessary for diagnosis, such as microscopic exams and tests of cysts from oral surgery.

## Major Dental Care

- **Network coverage:** Pays 50 percent of the negotiated fees with no deductible.
- **Out-of-network coverage:** Pays 50 percent of UCCI's allowance after you pay the deductible (except TMJ, see below). You pay the difference between your dentist's fees and UCCI's allowance.

Covered major dental care includes the following:

- **Prosthodontics:** Initial installation of bridgework and full or partial dentures is covered under this part of the plan. Benefits payable for both a temporary and permanent appliance are limited to covered charges for the permanent appliance. (Charges for extractions and other preparatory work, as well as repair, adjustment, recementing, relining, rebasing and adding teeth to existing dentures more than six months after their initial installation are covered under basic dental care.)
- **Cast Restorations:** Initial installation of crowns and inlays is covered under this part of the plan. Gold inlays, gold onlays and gold fillings and gold and porcelain crowns are covered only when the tooth can't be restored with fillings using the materials covered under basic dental care. If the other materials can be used, benefits for the gold restoration will be limited to the amount that would be paid for the alternate materials.
- **Dental implants:** Dental implants are covered only if they're used to replace natural teeth lost while the patient is covered under the plan. Before you receive services, you must contact UCCI for approval of the services.

- **Nonsurgical treatment of temporomandibular joint dysfunction (TMJ), including Occlusal guards:** The out-of-network coverage pays 50 percent of UCCI's allowance, but there is *no deductible* required for this coverage. Nonsurgical treatment of TMJ has a lifetime benefit maximum of \$750 per covered member of your household. These benefits aren't counted when determining if the plan's annual benefit maximums have been reached.

Treatment for TMJ includes examinations and the installation and adjustment of removable appliances designed to correct the condition. Charges for surgery to correct TMJ aren't covered under this plan, but may be covered under your medical plan.

### **Orthodontic Care**

You don't have to pay a deductible before orthodontia benefits can be paid. You pay the difference between your dentist's fees and UCCI's allowance. Any network orthodontia benefits you use count toward your maximum out-of-network orthodontia benefits. Similarly, any out-of-network orthodontia benefits you use count toward your maximum network orthodontia benefits. For example, if a plan member has received \$500 in benefits for orthodontic care under network coverage and \$500 under out-of-network coverage, no further out-of-network orthodontia benefits are payable for that individual, because the \$1,000 lifetime benefit maximum has been reached. However, that individual could qualify for another \$500 in orthodontic care benefits under the plan's network coverage — bringing total paid benefits up to the \$1,500 lifetime network coverage benefit maximum. If installation of appliances occurs before plan coverage is in effect, orthodontic services will be covered on a prorated basis once coverage begins under the plan.

- **Network coverage:** Pays 50 percent of the negotiated fees for braces and other teeth-straightening services and appliances, including second opinions. There is a lifetime benefit maximum of \$1,500 per plan member.
- **Out-of-network coverage:** Pays 50 percent of UCCI's allowance for braces and other teeth-straightening services and appliances, including second opinions. There is a lifetime benefit maximum of \$1,000 per plan member.

Benefits paid for orthodontic care don't count toward the plan's annual individual benefit maximums.

If you go to an out-of-network dentist for care, you should ask the dentist to prepare a request for predetermination of benefits and send it to UCCI, the plan's claims administrator, before orthodontic treatments are started. That way, you and your orthodontist will find out in advance how much the plan's out-of-network coverage will pay for the treatment and what you'll be required to pay.

The plan's orthodontia benefits for network coverage are paid in equal installments. Payments begin when the first orthodontic appliance is inserted. The last payment is made approximately two years after payments begin or, if sooner, when the treatment is completed, or will cease when that individual's coverage in the plan ends.

**Note:** Charges for tooth extractions and space maintainers prescribed as part of an orthodontic treatment plan are covered under basic dental care.

## If Your Care Costs More Than \$300

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If the dental care you need is expected to cost more than \$300, you can find out, before you receive care, how much you will pay and how much the plan will pay.

Just ask your dentist to request a predetermination of benefits by submitting a pre-treatment estimate request online or by mail, using the UCCI claim form. Your dentist should describe the treatment he or she recommends and send it to UCCI, the plan's claims administrator. You can get a copy of the predetermination of benefits claim form from UCCI's customer service group at 1-877-424-3876. Or, you can request the form from the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).

UCCI will send you a letter explaining how much the plan's coverage will pay for the proposed care. In some cases, the letter also will include suggestions for alternative treatments that are less expensive than those your dentist recommends.

It's important for you and your dentist to get this information before treatment begins because the benefits paid will be based on covered charges for the least expensive service or supply considered professionally adequate treatment, as determined by UCCI, the plan's claims administrator.

Note that requesting a predetermination is not a requirement nor is it considered a submission of a claim. Also, a predetermination of benefits is not binding.

## Expenses That Aren't Covered

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In certain situations, your Dental PPO benefits — or your eligibility for them — may be limited. For example, the plan doesn't pay for the following:

- Charges for treatment or services that aren't prescribed as medically necessary by a dentist or a doctor (although not all treatment or services prescribed by a dentist are considered covered charges).
- If alternate services or supplies are available for your treatment, charges you incur that exceed the least expensive service or supply considered professionally adequate treatment, as determined by UCCI, the plan's claims administrator.
- Hospital room and board, and any associated hospitalization costs (such as facility-use fees).
- Charges for services rendered while the patient isn't covered by the plan (however, coverage is provided for charges for dentures, bridgework, crowns and inlays that are initiated/ordered while the patient is covered under the plan and that are delivered within 90 days after coverage ends, and coverage is provided for charges for root canal therapy if the tooth is opened while the patient is covered under this plan and treatment is completed within 90 days after coverage ends).
- Charges you're not required to pay or charges that wouldn't be made if there were no coverage under this plan.
- Charges for treatment, supplies or services provided by an immediate relative of the covered individual or someone who normally lives with the covered individual.
- Charges for which a claim for benefits isn't filed within six months (by June 30) following the calendar year in which the service was provided.
- Dentures, bridgework, crowns and inlays ordered before the patient becomes covered under the plan.
- Extra sets or replacement of lost or stolen dentures, retainers or other appliances.
- Treatment or services provided by a government facility, doctor or dentist, or payable under a government plan or program, except as required by law.
- Dental implants or related services or devices which were not approved by UCCI before services were received.
- Experimental or investigative procedures, drugs or devices not generally recognized as being safe and effective, as determined by UCCI.

- Treatment of an injury or any dental condition that results from the patient's active participation in any of the following:
  - An insurrection or riot.
  - A crime, unlawful act or attempted crime.
  - War or any act of war (declared or undeclared) or international armed conflict or conflict involving armed forces of any international authority.
- Treatment of an injury or other loss that results from service in the armed forces of any government or international authority.
- Treatments provided by someone other than a dentist or doctor, except for treatment provided by a qualified technician or licensed dental hygienist under the supervision of a dentist or doctor.
- Cosmetic services or supplies, such as for teeth whitening.
- Porcelain facings on crowns or bridgework on back teeth.
- Training in or supplies used for dietary counseling, oral hygiene, plaque control, and tobacco counseling.
- Prescription drugs, and non-prescription drugs, vitamins, or dietary supplements.
- Charges for Nitrous Oxide over age 12.
- Procedures, restorations or appliances to increase vertical dimension or to restore occlusion, except as covered under treatment for TMJ.
- Root canal therapy if the tooth has been opened and drained prior to the effective date of coverage under this plan.
- Crowns and restorations for any tooth not broken down by decay or traumatic injury.
- Orthodontic care, services or appliances received before the patient became covered under this plan except as noted under covered charges.
- Services and supplies for injuries sustained while engaged in any occupation for remuneration or profit or in connection with a disease or injury for which workers' compensation or similar benefits are payable, or in connection with a disease or injury for which benefits are payable under state or federal disability laws.
- Charges for partial procedures performed by a dentist, unless the partial procedure is a result of or due to additional services performed at the same visit, as determined by and at the sole discretion of UCCI.
- Charges for dental consultations, unless accompanied by a limited oral evaluation diagnostic code and limited to one per dentist per patient per 12-month period.



- Charges for congenital mouth malformations or skeletal imbalances (e.g., treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).
- Treatment for of malignancies or neoplasms, including biopsies.
- Services and or appliances, crowns and fillings, for the purpose of restoring tooth structure lost from wear, including attrition, erosion or abrasion, or any other method of wear.
- Elective procedures (e.g., prophylactic extraction of third molars).
- Preventive restorations.
- Periodontal splinting of teeth by any method.
- Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
- Facial photographs.
- Genetic tests for susceptibility to oral disease and caries susceptibility tests.
- Viral cultures.
- Any procedure that is not a standard dental procedure and/or part of an enhanced benefit not currently covered under the Dental PPO.

Major services are limited as follows:

- Charges for a gold filling or crown are limited to the cost of a silver, porcelain or other filling, unless the tooth can't be restored with those materials.
- Charges for personalized restorations or characterizations of prosthetic appliances aren't covered.
- Charges for both a temporary and permanent prosthesis are limited to the charges for the permanent one. (To be covered, the prosthetic device must be necessary due to the loss of natural teeth or an unserviceable existing device.).
- Charges to replace gold fillings, crowns, bridgework or dentures less than five years old aren't covered.

If you or your dependent is injured by someone else's action or failure to act, or expenses are reimbursable under no-fault automobile insurance, benefits are provided under the plan only if you or your dependent agrees to reimburse the plan for all charges paid by the plan once damages are recovered from that person.

# Dental PPO Claims and Appeals

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

## How to File a Dental Claim

If you go to a network dentist when you need dental care, you don't have to file a claim form to get plan benefits. The plan pays your dentist directly. You pay any required coinsurance directly to your dentist.

If you go to an out-of-network dentist for care, you have to file a claim form to receive reimbursement of covered expenses. You should file your dental claims as soon as you incur covered charges, even if you haven't satisfied out-of-network coverage deductible requirements. Claim forms are available from the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). You also can obtain forms from the Benefits Connection website at [hr2.chevron.com](http://hr2.chevron.com) or UCCI's website at [www.ucci.com](http://www.ucci.com).

When you fill out the claim form, use your full name and include your member ID number. Attach all the bills and receipts you received for the services and supplies provided, ask your dentist to sign the completed claim form and mail it to:

United Concordia Companies, Inc.  
Dental Claims Department  
P.O. Box 69421  
Harrisburg, PA 17106-9421

If you have questions about a submitted claim, wait at least three weeks after you send in the claim form and then call UCCI at 1-877-424-3876 between 8 a.m. and 5 p.m. Pacific time, Monday through Friday.

You must file a claim for payment of plan benefits no later than six months (by June 30) following the calendar year in which the service was provided. If you don't file a proper claim with UCCI within this time frame, benefits for that service will be denied.

The claims administrator will not reimburse third parties who have purchased or have been assigned benefits by dentists or other providers.

If your claim is denied, or if UCCI needs more information before it can approve your claim, you'll be notified in writing. When a claim is denied, you can appeal the denial.

## Initial Claim Review and Decision

When you file a claim, the dental claims administrator (UCCI or its delegate) reviews the claim and makes a decision to either approve or deny the claim (in whole or in part). You will receive a written notice of the claim decision within the time limits described in the chart that follows.

Generally, all claims under the Dental PPO will be postservice claims. A postservice claim is any claim that does not require approval before you receive services, and that is filed for payment of benefits after care has been received.

### Time Limits for Processing Claims

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

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

Time Limits For Processing Claims	
Time Limits	Postservice Dental Claims
<b>Your deadline to provide additional information required by the plan to decide your claim</b>	<b>45 days</b> after receiving notice that additional information is required.
<b>Plan notice of initial claim decision</b>	<ol style="list-style-type: none"> <li>1. <b>Not later than 30 days</b> after receiving the initial claim, unless an extension, up to 15 days, is necessary due to matters beyond the control of the plan. The maximum time period is 45 days. You will be notified within the initial 30 days if an extension is needed.</li> <li>2. <b>Not later than 30 days</b> after receiving the initial claim, unless you need to provide additional information. You will be notified during the initial 30-day period, and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving your additional information or after the expiration of your 45-day deadline to complete the claim, whichever is earlier.</li> </ol>

## Notice and Payment of Claims

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

If your claim is approved, benefits will be paid to you unless the provider notifies the claims administrator that your signature is on file, assigning benefits directly to that provider. The claims administrator will not reimburse third parties who have purchased or have been assigned benefits by doctors or other providers.

If your claim is denied, there is an additional procedure for appealing a denied decision.

You should also be aware that the claims administrators have the right to request repayment if they overpay a claim for any reason.

## If Your Claim Is Denied

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

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

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

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

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

The claims administrator processes payments for claims, answers questions and reviews appeals according to the plan's provisions.

## How to File an Appeal

This section describes how to file an appeal and the time limits that apply.

Time Limits for Processing Dental PPO Appeals	
Time Limits	Postservice Dental Claims
Your deadline to file a first appeal	<b>180 days</b> after receiving the claim denial notice.
Plan notice of first appeal decision	<b>Not later than 30 days</b> after receiving an appeal.
Your deadline to file a second appeal	<b>90 days</b> after receiving the first appeal denial notice.
Plan notice of second appeal decision	<b>Not later than 30 days</b> after receiving a second appeal.

### First Appeal

After receiving the notice of denial, you or your authorized representative (this can be your provider, your beneficiary, your legal representative or another appropriately authorized individual) may ask for an appeal, which is a full and fair review of the initial claim decision, by writing to the claims administrator. You must make this request for an appeal in writing within the time limits noted in the chart above. During the time limit for requesting an appeal, upon request and free of charge, you or your authorized representative will be given reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits. Your appeal should include *all* of the following:

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

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

### Where to Send Your Appeal

The Dental Plan offers two levels of appeals. Send your appeals to:

United Concordia Companies, Inc.  
Dental Customer Service Department  
P.O. Box 69420  
Harrisburg, PA 17106-9420

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

### **Time Limits and Procedures for Processing Your First Appeal**

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

- The review on appeal will not afford deference to the initial denial, and it will be conducted by a fiduciary who is neither the individual who initially denied the claim that is the subject of the appeal nor the subordinate of such individual.
- If your claim is denied based in whole or in part on a medical judgment — including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate — the fiduciary reviewing the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.
- The health care professional consulted by the fiduciary reviewing the appeal will be an individual who is neither an individual who was consulted in connection with the denial of the claim that is the subject of the appeal nor the subordinate of such individual.
- Upon your request, the claims administrator will identify any medical or vocational experts whose advice was obtained on behalf of the plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

### **Notice of Decision on First Appeal**

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

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

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

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

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

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

## **Second Appeal**

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

### **Time Limits and Procedures for Processing Your Second Appeal**

Upon receipt of your second appeal, the claims administrator reviews the claim again and makes a decision based on all comments, documents, records and other information you've submitted, without regard to whether such information was submitted or considered in the initial benefit determination. This second appeal will be completed within the time limits shown in the chart above, *Time Limits for Processing Dental PPO Appeals*. The second appeal will follow the same procedural steps as described for the first appeal.

### **Notice of Decision on Second Appeal**

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

If your second appeal is denied (in whole or in part), you will receive a written notice. The notice will contain information sufficient to identify the claim involved. The notice will state the reasons for the denial, including references to specific plan provisions upon which the denial was based and a statement of your right to file a civil lawsuit under Section 502(a) of ERISA.

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

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

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

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

## **Administrative Power and Responsibilities**

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



## If You're Covered by More Than One Plan

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Coordination of benefits is a feature used to determine how much the Dental PPO will pay when you or one of your dependents is covered by more than one group insurance plan. This feature is designed to prevent overpayment of benefits.

### How It Works

Under the coordination of benefits rules, one plan pays benefits first (the "primary payer") and one plan pays second (the "secondary payer"). (See below for explanations of "primary payer" and "secondary payer.") The primary payer pays the benefits provided by its plan features. The secondary payer then pays any excess amounts required to bring the total benefits paid up to the levels payable under its plan.

If the Dental PPO is the secondary payer, plan benefits cannot be more than the negotiated fees or UCCI's allowance, but not to exceed your responsibility under the primary plan.

Different coordination of benefits rules apply under different circumstances.

Coordination of benefits doesn't apply to medical or dental HMOs available to Chevron employees or to individual (nongroup) dental care insurance policies.

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

A plan other than your Dental PPO will be the primary payer if any of the following conditions applies to the other plan:

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

When you or a dependent is covered under both the Dental PPO and a Medical PPO Plan, the Dental PPO Plan will be the primary payer for services or supplies that are covered under both plans.

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

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

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

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

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

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



# Mental Health and Substance Abuse Plan

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

- ValueOptions

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**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.**

# Overview

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- The MHSA plan covers treatment for mental health and substance abuse problems. For example, the plan may cover services for depression, stress/anxiety, parenting and family problems, relationship difficulties or problems at work, substance abuse and recovery, dealing with domestic violence, eating disorders and others.
- You're automatically covered if you're an eligible Chevron retiree not eligible for Medicare and enrolled in the Medical PPO plan. If your dependents are enrolled in the Medical PPO plan and are not eligible for Medicare, they're also automatically covered under this plan.
- If you're enrolled in an HMO offered by Chevron, your mental health and substance abuse benefits may be provided by the HMO; you are not eligible to participate in this plan. Please refer to your HMO's Evidence of Coverage for additional information.
- Chevron currently pays the full monthly premium cost for this coverage as part of its contributions toward your medical plan coverage.
- ValueOptions is the claims administrator for the plan and helps manage your benefits. ValueOptions can be reached 24 hours a day, seven days a week at 1-800-847-2438.

ValueOptions services include help with:

- Locating providers in the network.
  - Answering questions about mental health and substance abuse concerns.
  - Answering questions about your plan coverage.
  - Monitoring treatment progress.
  - Resolving problems or concerns you may have with your treatment.
  - Providing preauthorization, when necessary.
- You will receive a higher level of coverage if you use a provider that is in the ValueOptions network. The network includes more than 33,000 psychotherapists, social workers and psychologists who are experts in treating mental health and substance abuse problems. The network also includes 1,600 hospitals and residential care facilities nationwide.
  - To be considered an eligible expense under the plan, certain services require notification to ValueOptions. If you do not notify Value Options when you receive services, the service may not be covered, or in some cases you will pay a much higher percentage for your care.
  - Coverage for you or your dependent under the MHSA Plan ends when you or your dependent becomes eligible for Medicare.
  - When you call ValueOptions, your privacy and that of your dependents will be respected. The nature of your call will be kept confidential, unless there's an immediate threat to life or health.

## How the Plan Works

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

### **If you go to a Network Provider**

Generally, the plan pays a higher level of reimbursement for care when you use a provider in the ValueOptions network. Network providers charge discounted rates for covered services they provide to plan members and the plan benefits are based on these discounted rates. In addition, you do not have to file a claim form if you use a network provider. Certain services require preauthorization by ValueOptions. If you do not receive preauthorization before you receive services, the service will not be covered, or in some cases you will pay a much higher percentage for your care. To get a list of providers in your area, call ValueOptions at 1-800-847-2438.

### **If you go to an Out-of-Network Provider**

Generally, the plan pays lower benefits for care when you go to an out-of-network provider and the plan benefits are based on allowed charges. In addition, you typically will be required to pay for the services when you receive them and submit a claim form to be reimbursed. Certain services do require preauthorization by ValueOptions. If you do not receive preauthorization before you receive services, the service will not be covered, or in some cases you will pay a much higher percentage for your care.

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

## If You're Eligible for Medicare

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Coverage under the Mental Health and Substance Abuse Plan ends when you or your dependents become eligible for Medicare or you enroll in a Medical HMO plan offered by Chevron (if available).

## Deductible

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There is no deductible for this plan.



# Out-of-Pocket Maximum Feature

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

Under this feature, after your out-of-pocket costs reach the specified amount for the coverage tier, the plan pays 100 percent of all covered charges until the end of the calendar year.

Annual Out-of-Pocket Maximum Feature	
You Only	\$2,000
You + Adult	\$4,000
You + Children	\$4,000
You and Family	\$6,000

Each covered individual has a maximum out-of-pocket amount equal to the “You Only” out-of-pocket maximum amount. For the “You and Family” coverage category level, there is an overall maximum out-of-pocket amount for all covered participants. No more than the “You Only” amount can be applied for any one person to satisfy the “You and Family” out-of-pocket.

For example, if you and your eligible dependents are covered, your annual out-of-pocket maximum is met when the family’s accumulation of out-of-pocket costs reaches \$6000 with no more than \$2,000 applied for each family member. Your family could meet the \$6000 maximum limit with charges of \$2,000 for one member, \$1,500 for a second member, \$1,500 for a third member and \$1,000 for a fourth member.

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

- Charges in excess of covered charges.
- Charges for services, supplies or treatments that are not covered under the MHSA plan.
- Charges for services, supplies or treatments from a Network Provider that are in excess of the Network Provider Charges.
- Charges for services, supplies or treatments from an Out-of-Network Provider that are in excess of the Allowed Charges.
- Charges resulting from the failure to meet the notification requirements.

## What the Plan Pays

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This section provides information about the network and out-of-network benefits for covered services. In certain situations, to receive the full benefits, you have to follow certain notification procedures. For more information see the *Notification* section that follows and the description of benefits below. Keep in mind that the plan only pays benefits for covered charges for services, supplies, and treatment that are medically necessary and appropriate, as determined by ValueOptions.

### Notification to ValueOptions

You can contact ValueOptions at 1-800-847-2438. If you do not notify ValueOptions as indicated below, the service may not be covered because only medically necessary and appropriate treatment is covered, or in some cases you will pay a much higher percentage for your care. To notify ValueOptions, your provider submits a proposed treatment plan to ValueOptions who will review the plan and advise your provider how many visits (or days of inpatient care) will be covered based on your medical need. Your provider periodically touches base with ValueOptions to ensure that your treatment plan continues to be covered. If the treatment plan is not covered, ValueOptions will advise your provider. It is your responsibility to notify ValueOptions or ensure that your provider does so that you receive the maximum level of benefits available under the plan. Refer to the information below for details about when notification is required for each type of service.

## Mental Health Benefits

<b>Inpatient Care</b> – includes acute inpatient treatment, residential treatment, day treatment (including structured outpatient treatment, intensive outpatient treatment and partial hospitalization)	
<b>Network</b>	90% of contracted rates Requires notification to ValueOptions within 2 business days of admittance.
<b>Out-of-Network</b>	80% of allowed charges. Requires notification to ValueOptions within 2 business days of admittance.

The plan provides coverage for inpatient treatment while confined in a hospital and residential treatment which is generally acute or higher level 24-hour care than services delivered for day or structured outpatient treatment. This includes charges for prescription drugs if provided specifically as part of inpatient or residential treatment care. The plan also provides coverage for day treatment and structured outpatient treatment, which is generally less acute care where the patient is in a day or evening program for generally 3-6 hours per day, 3-5 days per week without an overnight stay. No plan benefits are paid for custodial care.

**Notification to ValueOptions:** If you or your provider does not notify ValueOptions within 2 business days of receiving services, you may pay a much higher percentage for your care. Notification to ValueOptions allows ValueOptions to review your provider's proposed treatment plan for medical necessity and advise your provider how many visits or days of care will be covered based on your medical need. You or your provider periodically touches base with ValueOptions to ensure that your treatment plan continues to be covered. If the treatment plan is not covered, ValueOptions will advise your provider. **If notification requirements are not met but the services are covered charges, the plan will pay 60% of contracted rate for a network provider (or the rate ValueOptions has negotiated for not providing notification, if lower) and 60% of the allowed charges for an out-of-network provider.**

<b>Outpatient Office Visits</b>	
<b>Network</b>	90% of contracted rates.
<b>Out-of-Network</b>	80% of allowed charges.

The plan provides coverage for outpatient office visits for the treatment of mental health problems. Included is treatment for serious conditions, such as depression, stress/anxiety, substance abuse, eating disorders, as well as everyday challenges such as family stress, relationship difficulties and problems at work. Outpatient services must meet medical necessity as determined by ValueOptions. The Mental Health and Substance Abuse Plan doesn't cover prescription drugs for outpatient office visit treatment. If you're prescribed a drug as part of your outpatient treatment, you should check with Express Scripts to find out if your prescription drug benefit can help pay for the drugs you need; otherwise, you'll be responsible for paying the full cost of prescribed outpatient medication. ValueOptions (1-800-847-2438) can help you locate a ValueOptions network provider in your area.

<b>Emergency Treatment</b>	
<b>Network</b>	90% of contracted rates
<b>Out-of-Network</b>	90% of billed charges

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

Psychological Tests	
U.S. Network	90% of contracted rates.
U.S. Out-of-Network	80% of allowed charges.

The plan covers psychological testing when used to diagnose a mental health disorder or when given in conjunction with a diagnosed/covered psychiatric disorder. Psychological testing for learning disabilities is not covered. Outpatient and inpatient psychological tests require advance notification to ValueOptions and must be medically necessary and appropriate. **If notification requirements are not met but the charges are covered charges, the plan will pay 60 percent of contracted rate for a network provider (or the rate ValueOptions has negotiated for not providing notification, if lower) and 60 percent of the allowed charges for an out-of-network provider.**

## Substance Abuse Benefits

Inpatient Care – includes acute inpatient treatment, residential treatment, day treatment (including structured outpatient treatment, intensive outpatient treatment and partial hospitalization)	
Network	100% of the first \$5,000 of contracted rates; 90% of contracted rates over \$5,000. Requires notification to ValueOptions within 2 business days of admission for inpatient treatment.
Out-of-Network	80% of allowed charges. Requires notification to ValueOptions within 2 business days of admission for inpatient treatment. Without notification, coverage is 60% of allowed charges.

The plan provides coverage for inpatient treatment while confined to a hospital and residential treatment which is generally acute or higher level 24-hour care than services delivered for day or structured outpatient treatment. This includes charges for prescription drugs if provided specifically as part of inpatient or residential treatment. The plan also provides coverage for day treatment and structured outpatient treatment, which is generally less acute care where the patient is in a day or evening program for generally 3-6 hours per day, 3-6 days per week without an overnight stay. No plan benefits are paid for custodial care.

**Notification to ValueOptions.** If you or an eligible dependent needs help with a substance abuse problem on an inpatient basis, you must notify ValueOptions. If you or your provider does not notify ValueOptions within 2 business days of receiving services, your treatment may not be covered or you will pay a much higher percentage for your care. Notification allows your provider to submit a proposed treatment plan. ValueOptions reviews the plan for medical necessity and advises your provider how many visits or days of care will be covered based on your medical need. You or your provider periodically touches base with ValueOptions, as appropriate, to ensure that your treatment plan continues to be covered. If the treatment plan will not be covered, ValueOptions will advise your provider. **If notification requirements are not met but the charges are covered charges, the plan will pay 60% of contracted rate for a network provider (or the rate ValueOptions has negotiated for not providing notification, if lower) and 60% of the allowed charges for an out-of-network provider.**

<b>Office Visits</b>	
<b>Network</b>	90% of contracted rates.
<b>Out-of-Network</b>	80% of allowed charges

The plan provides coverage for outpatient office visits for the treatment of substance abuse problems. The Mental Health and Substance Abuse Plan doesn't cover prescription drugs for outpatient office visit treatment. If you're prescribed a drug as part of your outpatient treatment, you should check with Express Scripts to find out if your prescription drug benefit can help pay for the drugs you need; otherwise, you'll be responsible for paying the full cost of prescribed outpatient medication. ValueOptions (1-800-847-2438) can help you locate a ValueOptions network provider in your area.

<b>Emergency Treatment</b>	
<b>Network</b>	90% of contracted rates.
<b>Out-of-Network</b>	90% of billed charges.

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

## Expenses That Aren't Covered

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

- Treatment, supplies or services not prescribed by a clinician (although not all treatment or services prescribed by a clinician are considered covered charges).
- Services that aren't considered medically necessary and appropriate, as determined by ValueOptions.
- Charges that you're not required to pay.
- Charges in excess of allowed charges.
- Charges for which a claim for benefits isn't filed within six months (by June 30) following the year in which the covered charge is incurred.
- Treatment provided by an immediate relative or someone who normally lives with you.
- Treatment, supplies or services furnished by a government facility or doctor, or payable under a government plan or program, except as required by law.
- Treatment of an injury that results from the patient's active participation in any of the following:
  - An insurrection or riot.
  - A crime, unlawful act or attempted crime.
  - War or any act of war (declared or undeclared) or international armed conflict or conflict involving armed forces of any international authority.
- Treatment of an injury or other loss that results from service in the armed forces of any government or international authority.
- Treatment for a condition covered by workers' compensation or other occupational disease law or sustained while working for compensation, profit or gain.
- Charges of a personal nature, such as the cost of newspapers, telephone, guest meals or rental of radios, television or bedside service tables, posture chairs and exercise equipment.
- Transportation costs, unless approved in advance by ValueOptions as medically necessary and appropriate.
- Charges that are reimbursed by an award or settlement that you receive from a third party for expenses for treating an injury or condition resulting from an act, or failure to act, of the third party.
- Experimental procedures, drugs or devices, as determined by ValueOptions in its sole discretion.
- Charges for services rendered while the patient isn't covered by the plan.

- Custodial care.
- Educational rehabilitation or treatment of learning disabilities (including Pervasive Development Disorder and Autism Spectrum Disorder).
- Charges for broken appointments or completing or filing claim forms.
- Charges for treatment of physical illness, including, but not limited to, cirrhosis and neurological disorders.
- Charges for services, supplies or treatment that are covered charges under the Medical PPO Plan or another health care plan to which Chevron contributes, such as an HMO, including prescription drugs prescribed as part of outpatient treatment.
- Services furnished in response to a court order that aren't medically necessary and appropriate.
- Treatment of chronic pain, except for psychotherapy, biofeedback or hypnotherapy given in connection with a diagnosed psychiatric disorder.
- Aversion therapy.
- Treatment for personal growth or development.
- Treatment received to fulfill a requirement for professional certification.
- Charges for hypnotherapy, except when performed in connection with a diagnosed mental health disorder.
- Psychological testing, unless used to diagnose a mental health disorder or when given in conjunction with a diagnosed psychiatric disorder.
- Psychiatric or psychological examination, testing or treatments for obtaining or maintaining employment or insurance or relating to judicial or administrative proceedings.
- Private-Duty nursing, except when preapproved by ValueOptions as medically necessary and appropriate in a managed care environment.
- Prescription drugs, except drugs dispensed by a hospital or by a residential or day treatment program.

# MHSA Plan Claims and Appeals

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

## How to File a Claim

If you call ValueOptions or Chevron's Employee Assistance and WorkLife Services for a referral — and go to a ValueOptions network provider for care — you generally don't have to file a claim form for network benefits. However, before your benefits can be paid, you must sign an authorization to release medical information. ValueOptions will send you an authorization form, or your provider may give you the form. Your provider will make arrangements with you if you need to pay for part of your treatment.

You may be billed directly by a provider if you live in an area where ValueOptions doesn't have any providers in its network and you receive treatment from another facility or provider that ValueOptions or Chevron's Employee Assistance and WorkLife Services refers you to. If so, to be reimbursed for treatment, you'll have to file a claim form with ValueOptions.

You also have to file a claim form if you use an out-of network provider for services. You can get a claim form from ValueOptions by calling 1-800-847-2438. Claim forms are also available on the Benefits Connection website at [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree) or from the HR Service Center. To ensure timely payment, you should file your claim as soon as you can. If you don't file a claim within six months (by June 30) following the year in which you incur a covered charge, no plan benefits will be payable for that covered charge.

## Initial Claim Review and Decision

When you file a claim, the claims administrator (ValueOptions or its delegate) reviews the claim and makes a decision to either approve or deny the claim (in whole or in part). You'll receive written notice of the status of your claim within 30 days after ValueOptions receives it. If there are special circumstances that require more time, ValueOptions will advise you that more time is needed and will send its decision within 45 days of receiving the claim. If additional information is needed, you will be notified during the initial 30-day period and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving your additional information or after the expiration of your 45-day deadline to complete the claim, whichever is earlier. Note, different time limits apply for urgent care and pre-service claims as described in the *Time Limits for Processing Claims* chart below. If your claim is denied, or if ValueOptions needs more information before it can approve your claim, you'll be notified in writing. When a claim is denied, you can appeal the denial, as described further below. If your dispute concerns eligibility to participate in the plan, you must follow the procedures described in the How to File a Claim for Eligibility section of this summary plan description.



## Types of Claims

You will receive a written notice of the claim decision within the time limits described in the *Time Limits for Processing Claims* chart below. Those time limits are based on the type of claim and whether you submit a proper claim, including all necessary information. There are generally three types of claims with respect to an ERISA group health plan:

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

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

## Time Limits for Processing Claims

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

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

<b>Time Limits for Processing Claims</b>			
<i>This chart describes the time limits for processing different types of claims.</i>			
Time Limits	Types of Claims		
	Urgent Care Health Claims	Preservice Health Claims	Postservice Health Claims
<b>Plan notice of failure to follow the proper claim procedures</b>	<b>Not later than 24 hours</b> after receiving the improper claim.	<b>Not later than 5 days</b> after receiving the improper claim.	<b>N/A</b>
<b>Your deadline to provide additional information required by the plan to decide your claim</b>	<b>48 hours</b> after receiving notice that additional information is required.	<b>45 days</b> after receiving notice that additional information is required.	<b>45 days</b> after receiving notice that additional information is required.
<b>Plan notice of initial claim decision</b>	<p>1. <b>Not later than 72 hours</b> after receiving the initial claim, if it was proper and complete.</p> <p>2. <b>Not later than 48 hours</b> after receiving additional information or after the expiration of your 48-hour deadline to provide such information to complete the claim, whichever is earlier</p>	<p>1. <b>Not later than 15 days</b> after receiving the initial claim, unless an extension, up to 15 days, is necessary due to matters beyond the control of the plan. The maximum time period is 30 days total. You will be notified within the initial 15 days if an extension is needed.</p> <p>2. <b>Not later than 15 days</b> after receiving the initial claim, unless you need to provide additional information. You will be notified during the initial 15-day period and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving your additional information or after the expiration of your 45-day deadline to complete the claim, whichever is earlier.</p>	<p>1. <b>Not later than 30 days</b> after receiving the initial claim, unless an extension, up to 15 days, is necessary due to matters beyond the control of the plan. The maximum time period is 45 days total. You will be notified within the initial 30 days if an extension is needed.</p> <p>2. <b>Not later than 30 days</b> after receiving the initial claim, unless you need to provide additional information. You will be notified during the initial 30-day period, and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving your additional information or after the expiration of your 45-day deadline to complete the claim, whichever is earlier.</p>

### **Concurrent Care Claims**

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

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

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

### **Notice and Payment of Claims**

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

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

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

## If Your Claim Is Denied

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

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

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

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

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

## How to File an Appeal

This section describes how to file an appeal and the time limits that apply to the different types of medical appeals.

<b>Time Limits for Processing MHSAs Appeals</b>			
This chart describes the time limits for processing different types of appeals.			
Time Limits	Types of Claims		
	Urgent Care Health Claims	Preservice Health Claims	Postservice Health Claims
<b>Your deadline to file a first appeal</b>	<b>180 days</b> after receiving the claim denial notice.	<b>180 days</b> after receiving the claim denial notice.	<b>180 days</b> after receiving the claim denial notice.
<b>Plan notice of first appeal decision</b>	<b>Not later than 72 hours</b> after receiving an appeal.	<ol style="list-style-type: none"> <li><b>Not later than 15 days</b> after receiving an appeal, if the plan allows two levels of appeal.</li> <li><b>Not later than 30 days</b> after receiving an appeal, if the plan allows one level of appeal.</li> </ol>	<ol style="list-style-type: none"> <li><b>Not later than 30 days</b> after receiving an appeal, if the plan allows two levels of appeal.</li> <li><b>Not later than 60 days</b> after receiving an appeal, if the plan allows one level of appeal.</li> </ol>
<b>Your deadline to file a second appeal</b>	N/A	<b>90 days</b> after receiving the first appeal denial notice.	<b>90 days</b> after receiving the first appeal denial notice.
<b>Plan notice of second appeal decision</b>	N/A	<b>Not later than 15 days</b> after receiving a second appeal.	<b>Not later than 30 days</b> after receiving a second appeal.
<b>Your deadline to request an External Review</b>	<b>Four months</b> after receiving the appeal denial notice	<b>Four months</b> after receiving the second appeal denial notice	<b>Four months</b> after receiving the second appeal denial notice
<b>IRO notice of External Review Decision</b>	<b>Not later than 72 hours</b> after receiving the request for external review	<b>Not later than 45 days</b> after receiving the request for external review	<b>Not later than 45 days</b> after receiving the request for external review

## First Appeal

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

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

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

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

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

### Where to Send Your Appeal

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

ValueOptions  
Review Authority  
10805 Holder Street, Suite 300  
Cypress, CA 90630

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

### Time Limits and Procedures for Processing Your First Appeal

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

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

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

#### **Notice of Decision on First Appeal**

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

If your first appeal is denied (in whole or in part), you will receive a written notice. The notice will contain information sufficient to identify the claim involved. The notice will state the reasons for the denial, including references to specific plan provisions upon which the denial was based and a statement of your right to file a civil lawsuit under Section 502(a) of ERISA following an adverse determination after completion of all levels of appeal/review required by the plan. The notice will state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

If your first appeal is denied based on an internal rule, guideline, protocol or other similar item, the notice will include a copy of the rule, guideline, protocol or item that was relied on to deny the claim. Alternatively, the notice will include a statement that an internal rule, guideline, protocol or similar item was relied on to deny your claim, and you can request a copy of it (the rule, guideline, protocol or other similar item) free of charge. If your first appeal is denied based on medical necessity or experimental treatment or a similar exclusion or limit, the notice must include an explanation of the scientific or clinical judgment for the determination. It also must apply the terms of the plan to your medical circumstances. Alternatively, the notice will include a statement that such explanation will be provided to you free of charge upon request. The notice will include any additional information required by Department of Labor claim, appeal, and external review regulations. If, on the first appeal, the claims administrator upholds the denial of your claim and the claims administrator allows two levels of appeal, you may file a second appeal within 90 days after receiving the notice of denial of your first appeal.

## Second Appeal

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

### Time Limits and Procedures for Processing Your Second Appeal

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

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

### Notice of Decision on Second Appeal

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

If your second appeal is denied (in whole or in part), you will receive a written notice. The notice will contain information sufficient to identify the claim involved. The notice will state the reasons for the denial, including references to specific plan provisions upon which the denial was based and a statement of your right to file a civil lawsuit under Section 502(a) of ERISA after all levels of required appeal/review have been exhausted. The notice will explain how to request an external review. The notice will state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

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

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

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



## Requesting an External Review

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

- You were covered under the plan at the time the services were provided.
- The claim denial is not a result of failure to meet the requirements for eligibility under the plan.
- The claim denial involved medical judgment (for example, a denial based on the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit or a determination that a treatment is experimental or investigational) or the matter is a rescission of coverage.
- You have exhausted the appeal process described above. A de minimis (small) deviation from strict adherence of the internal claims and appeals procedure on the part of the relevant claims administrator or review panel that does not cause, or is not likely to cause, prejudice or harm to the claimant will not waive the requirement to exhaust the internal claims and review procedure before obtaining an external review. The claims administrator shall provide an explanation of such deviation within 10 days of the request of the claimant. If a request for external review is denied on account of the failure to exhaust the internal claims and appeals process when a de minimis deviation is involved, the claimant shall have the right to pursue the internal process.

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

### Expedited External Review

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

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

To request an expedited external review, contact ValueOptions:

ValueOptions  
Review Authority  
10805 Holder Street, Suite 300  
Cypress, CA 90630

### **Administrative Power and Responsibilities**

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

## If You're Covered by More Than One Plan

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

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

### How It Works

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

Different coordination of benefits rules apply under different circumstances.

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

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

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

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

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

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

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

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

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

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

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

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

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

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



# Medical and Dental HMO Supplement

This section provides a description of the Medical and Dental HMO Plan for you and your eligible dependents.

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**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.**

This section describes certain provisions that apply to health maintenance organization (HMO) plans offered by Chevron for eligible retirees and eligible dependents.

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. 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 HMO or DHMO 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 by visiting the Benefits Connection website at [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree).

## Overview

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- Chevron currently 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, prescription drug or mental health and substance abuse plan benefits provided by any of the other Chevron plans. If you choose a dental HMO, you are not eligible for dental benefits provided by another Chevron dental plan.
- 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 (EOC) (sometimes called a "certificate 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.



# Types of Health Maintenance Organizations (HMOs)

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## Medical HMO

Typically, HMOs are more cost-effective than preferred provider organization (PPO) plans. Under an HMO, once you pay a copayment, most covered 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 (unless you move outside of the HMO's 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, in order to keep costs lower, many HMOs have more stringent restrictions related to their prescription drug benefits.

## Medicare Advantage HMO

Medicare Advantage HMOs are usually less expensive than traditional Medicare supplement plans or traditional HMOs. Sometimes Medicare Advantage HMOs have a smaller network of doctors than a regular HMO, because not all doctors choose to accept Medicare assignments. And, as with regular HMOs, these networks may change during the year. With Medicare Advantage, the HMO makes a contract with Medicare to provide all of your benefits, including prescription drugs, through the HMO. The HMO receives a fixed monthly payment from Medicare for you, whether or not you see a doctor. If the cost of your care exceeds Medicare's payment for you, the HMO pays the balance. If your care costs less than Medicare's payment to your HMO, the HMO keeps the difference. The HMO may also provide benefits not covered by Medicare, such as prescription drugs, periodic physical or eye examinations, or eyeglasses. Medical services you receive from any provider outside your HMO (except in an emergency as determined by the HMO or with authorized referrals) will not be paid for by Medicare or the HMO. Medicare Advantage HMOs also are Medicare Part D prescription drug plans.

## Medicare Supplement HMO

These plans are offered primarily in areas where no Medicare Advantage HMOs are available. Medicare is your primary medical coverage, so when you use providers under these plans, they will coordinate benefits with Medicare. To receive the greatest benefit, you should receive all your care, including prescription drugs, through the HMO's providers. However, if your Medicare supplement plan allows you to use a provider outside the HMO network, you still can file a claim with Medicare. Some Medicare supplement HMOs also are Medicare Part D prescription drug plans.

## 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.

## Eligibility

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Chevron's HR Service Center can tell you which medical and dental HMO plans are available in the zip code where you live, or you can access that information through the Benefits Connection website at [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree).

You can participate in the medical and dental HMO plans offered by Chevron if you meet the qualifications of an "eligible retiree." In addition, if you're eligible and you enroll for coverage under one of the medical or dental HMO plans offered by Chevron, you must also enroll your eligible dependents for coverage under the same HMO. For example, if you have a family member who is Medicare-eligible and other family members who are not, then, to provide medical coverage for the entire family, all members must be enrolled with the same HMO carrier:

- The Medicare-eligible family member(s) would enroll in the HMO Medicare Advantage or HMO Medicare Supplement plan.
- The non-Medicare family member(s) must enroll in non-Medicare option of the same HMO, if that HMO offers a non-Medicare option.

In addition, if you choose to enroll in one of the medical HMO options, you are not eligible for benefits under the Chevron Mental Health and Substance Abuse Plan. You should check your HMO's Evidence of Coverage to determine what mental health and substance abuse benefits may be available to you under your HMO plan.

### **Get the Full Eligibility Requirements**

See the Eligibility and Participation section of this summary plan description for the detailed eligibility requirements for retirees and dependents for Chevron's health plans.

# Participation

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This section provides important information about your participation in Chevron's health plans for eligible retirees and eligible dependents.

## When and How You Can Enroll

Before you retired, you were provided with information about how to continue health plan coverage in retirement for yourself and your dependents. If you didn't elect to change health care coverage when you retired, you automatically continued to be covered under the plans in which you were enrolled, as long as the plans were available to retirees.

As a retiree, when you or one of your dependents becomes eligible for Medicare, you are required to select a plan that coordinates with Medicare if you have coverage with Chevron. The HR Service Center will send an enrollment package to you three months in advance of your (or your dependent's) 65th birthday. The package will describe the Medicare plan options available to you and instructions for enrollment. You will need to contact the HR Service Center to select a plan and provide your Medicare claim number. For some HMOs, you must complete an enrollment form. All Medicare and non-Medicare family members must be covered by the same Chevron plan.

If you acquire new dependents and they are to be covered under your health plans, you must enroll them within 31 days of the date they become eligible; otherwise, you will have to wait until the open enrollment period to enroll your dependents, and their coverage will not be effective until the first of the following year. You can enroll your dependents by contacting the HR Service Center or by accessing the Benefits Connection website at [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree).

If you're enrolled in a health plan, you can switch coverage to another plan to which Chevron contributes (if you're eligible) during Chevron's open enrollment period. You can switch coverage without providing proof of good health.

If you waive all health coverage during one open enrollment period, you may enroll in health care coverage during any subsequent open enrollment period. (If you're eligible for survivor coverage and you terminate all health care plan coverage, you become ineligible for coverage in the future.)

If you waive coverage because you are employed elsewhere and you're enrolled for health care coverage through that employer, you may re-enroll in Chevron health care coverage during any subsequent open enrollment period or when your coverage with the other employer ends if you enroll within 31 days of the date the other coverage ends. If you die while covered under another employer's plan, your eligible dependents who are covered under your plan on the date of your death may enroll in retiree and survivor coverage, provided the HR Service Center is notified within 31 days of your death.

If you're covered as a dependent under your spouse's health plan (non-Chevron coverage) and you become ineligible for that plan, you can enroll in a Chevron-sponsored health plan if you enroll within 31 days of the date the other coverage ends. (You will be required to provide proof that your other coverage ended.)

The open enrollment period is usually held in the fall, with changes becoming effective the following January 1.

Before a dependent's enrollment can be processed, you may be required to provide proof of the dependent's eligibility — such as your marriage license, a birth certificate or adoption papers, and you must file a notarized *Chevron Affidavit of Domestic Partnership (F-6)* form before you can enroll your domestic partner for health plan coverage. You can get a copy of the form from the HR Service Center or from the Benefits Connection website at [www.benefitsweb.com/chevron.html](http://www.benefitsweb.com/chevron.html).

If your eligible dependents weren't enrolled when you retired, you can enroll them during the open enrollment period or within 31 days of the date they first become eligible.

**Note**

To be covered under Mental Health and Substance Abuse Plan offered by Chevron, you and your dependents must be enrolled in the Chevron Medical PPO plan. Neither you nor your dependents can be covered under the Mental Health/Substance Abuse Plan if federal Medicare is the primary payer of your medical benefits. If you are in a HMO Plan sponsored by Chevron you are not eligible for the Mental Health and Substance Abuse Plan. Also, former Gulf, former Texaco, former Getty, former Caltex, and former Amoseas employees who retired before July 1, 2002, and their survivors, are not eligible for coverage under the Dental Plan sponsored by Chevron.

## Paying for Coverage

You and Chevron currently share the cost of your benefit plans. For more information, see Company Contributions for Retiree Health Care Coverage Supplement in this summary plan description.

## 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 in the fall) or when there's a qualifying life event during the year. Here's a brief explanation of changes you can make.

You can switch to another medical or dental plan (available in your area) during open enrollment held in the fall, or if you move out of the service area for the plan in which you're currently enrolled if you enroll within 31 days of the date the other coverage ends. You can change your dependent coverage elections during open enrollment or within 31 days of the date you have a qualifying life event (the qualifying event must be consistent with the change). You also can change your medical or dental elections during the year if you or a dependent qualifies for special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) if you enroll within 31 days of the date of the event.

If you're enrolled in the Medical PPO offered by Chevron, you and your enrolled dependents are automatically covered under the Mental Health and Substance Abuse Plan. This section only discusses the Medical and Dental HMOs. If you need information about the Mental Health and Substance Abuse Plan, see the corresponding chapter in this summary plan description.

There are no elections to change under this plan.

## 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 retiree health plan option for which you are eligible or, if you're already enrolled in a retiree 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," 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:

- 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 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.

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 retiree:** If you're eligible but haven't yet enrolled, you can enroll upon your marriage, upon acquiring a new domestic partner, or upon the birth, adoption or placement for adoption of your child.
- **Nonenrolled spouse/domestic partner:** If you're already enrolled, you can enroll your spouse/domestic partner at the time of your marriage or acquiring a new domestic partner. You also can enroll your spouse/domestic partner if you acquire a child through birth, adoption or placement for adoption.
- **New dependents of an enrolled retiree:** 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 retiree:** 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 retiree) 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 Plan Information** chapter, **Free or Low-Cost Health Coverage to Children and Families** section of this summary plan description.

## When Participation Begins

- **Retiree Coverage:** Generally, your health plan participation continues without interruption as soon as you became an eligible retiree (as defined in the Eligibility section), unless you elected to cancel coverage at retirement. When you or a dependent becomes eligible for Medicare, coverage for the participating person changes to a Medicare plan, generally on the first day of the month in which that person's 65th birthday occurs (unless your or your dependent's birth date is the first day of the month, then Medicare coverage is effective the first of the preceding month).
- **Dependent Coverage:** Health plan coverage for your eligible, enrolled dependents was continued without interruption as soon as you became an eligible retiree, unless you elected to cancel their coverage at retirement. Eligible newborn children become covered on their date of birth if you enroll them within 31 days of the date they're born. A newly adopted child becomes covered on the date of adoption or, if earlier, on the date the child is placed with you for adoption, if you enroll the child within 31 days. For other eligible dependents, such as a new spouse/domestic partner and new children or a new stepchild other than your newborn or newly adopted children, coverage begins on the first day of the month after they become eligible, if you enroll them within 31 days.
- **Open Enrollment:** If you switch to another health plan during the open enrollment period or enroll in retiree coverage after waiving it, coverage under the new plan begins the following January 1.

## When Participation Ends

Your retiree health plan coverage ends on the last day of the month in which any of the following occurs:

- You cancel your coverage.
- You stop making required contributions.
- You're re-employed by Chevron.
- Chevron Corporation terminates the plan.

Your dependents' coverage ends on the last day of the month in which any of the following occurs:

- They're no longer eligible.
- You cancel their coverage.
- You stop making required contributions.
- You're re-employed by Chevron.
- Chevron Corporation terminates the plan.

When you or your dependent becomes Medicare-eligible, coverage under your current plan will end. You'll then become eligible to join the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, the Chevron Senior Care Plan, or a Medicare Advantage HMO (if available in your area). *Note: the Chevron Medicare Plus Plan is not available to Unocal retirees who retired before July 1, 2006.* The medical plans for non-Medicare-eligible family members must correspond to the Medicare-coordinated plan selected by the member. Coverage for family members who are not eligible for Medicare and enrolled under the Medical PPO can continue to receive benefits under the Mental Health and Substance



Abuse Plan. This section only discusses the Medical and Dental HMOs. If you need information about the Mental Health and Substance Abuse Plan, see the corresponding chapter in this summary plan description.

If you move out of your health plan's service area, you must change to a plan offered where you live. Your new coverage will be effective on the first day of the following month.

**If you enroll in a separate Medicare prescription drug plan or any other non-Chevron-sponsored health plan with Medicare prescription drug coverage, your Chevron medical and prescription drug coverage will be terminated. You cannot be covered under both a Chevron retiree medical plan and another Medicare plan that offers prescription drug coverage at the same time. In addition, you may not be enrolled in an individual Medicare Advantage Plan – even one without prescription drug coverage – at the same time you are enrolled in a Chevron-sponsored retiree medical plan.**

There are other circumstances when participation for you or your dependents may end. For instance, 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).

**If you or a dependent is disabled when coverage ends**

If you or a dependent is hospitalized at the time coverage under the Chevron Medical Plans ends, benefits for charges incurred in the hospital can be paid until you or your dependent leaves the hospital.

**If, as a retiree, you die**

Your enrolled dependents may be eligible for either continuation coverage or survivor coverage. For more information, see the Continuation Coverage and COBRA Coverage section of this summary plan description. Chevron may pay a portion of the cost of this survivor coverage. While these plan rules determine health care benefit eligibility for your survivors, Chevron still may change plan benefits or end plan coverage at any time. This is true for those who retired in the past, as well as to those who retire in the future, and for their survivors. If a surviving spouse/domestic partner or dependent waives all health plan coverage or if coverage ends for any reason including nonpayment of premium, they become permanently ineligible for future health plan coverage and coverage will not be reinstated.

**COBRA coverage when retiree coverage ends**

Under the terms of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), your eligible dependents and survivors may be able to continue coverage after retiree coverage ends.

## How HMO Participation Affects Other Benefits

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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, vision, prescription drug, and mental health and substance abuse plan 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.

### **Mental Health and Substance Abuse Plan**

If you're enrolled in a medical HMO offered by Chevron, any mental health and substance abuse benefits are provided by the HMO. you are not eligible for the Chevron Mental Health and Substance Abuse (MHSA) Plan described in this summary plan description. Please refer to your HMO's Evidence of Coverage for additional information about mental health and substance abuse coverage.

## How to Contact Your HMO or DHMO

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If you choose HMO or DHMO coverage, the administrator for the plan is the HMO or DHMO you elect. For questions about your coverage and for a current list of network providers, 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 by visiting the Benefits Connection website at [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree).

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# Basic Life Insurance Plan for Former Chevron Employees

This section describes the Chevron life insurance plans in effect for the former Chevron employee grandfathered group. This plan pays benefits in the event of your death. The amount of coverage provided by the plan depends on several factors, including the amount of your pay at retirement and your age. If you are former Texaco employee and you retired or left Texaco before July 1, 2002, other benefit plan provisions may apply to you. *If you are a former Unocal employee and you retired or left Unocal or Chevron before July 1, 2006, other benefit plan provisions may apply to you.*

- MetLife

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**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.**

# Eligibility

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If you are a former Chevron employee, you're eligible for coverage under the Basic Life Insurance Plan if you meet *all* of the following requirements:

- On June 30, 2002, you had at least 20 years of continuous service or at least 65 points (age plus years of continuous service).
- You retire before July 1, 2007, with at least 25 years of health and welfare eligibility service or at least 75 points (age plus years of health and welfare eligibility service).
- You have not been rehired since July 1, 2002.

If you retired on or after July 1, 2002, but don't meet the qualifications above, you are not eligible for retiree life insurance under the Basic Life Insurance Plan.

You aren't eligible for retiree life insurance benefits if your employment with Chevron was terminated for misconduct, such as fraud, dishonesty or deliberate disregard of Chevron rules.

## **Supplemental Life Insurance Plan (for Former Chevron Employees)**

If you meet certain eligibility requirements, you may continue the amount of enrolled pre-retiree Supplemental Life Insurance at the employee rates. This insurance will automatically continue and you must contact the HR Service Center toll-free to cancel or reduce the coverage.

### **Health and Welfare Eligibility Service (HWES)**

Your health and welfare eligibility service is used to determine your eligibility for retiree health care benefits. For more information about HWES, see the Company Contributions to Medical Coverage Supplement included in this summary plan description.

# Participation

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If you meet the eligibility requirements, retiree life insurance coverage is automatic when you retire.

## Naming a Beneficiary

If you haven't already done so, you should name a beneficiary to receive any benefits that may be payable in the event of your death.

You can name more than one person as your beneficiary and they will share the life insurance benefit. If you name more than one beneficiary, be sure to designate what percentage of the entire benefit should be paid to each. The total must equal 100 percent. You also need to indicate the beneficiaries' relationship to you.

You can complete a *Designation of Beneficiary for Benefit Plans for Former Employees (F-73)* form. To request a form contact the HR Service Center at 1-888-825-5247 or (610-669-8595 outside the U.S.). You may also update your beneficiary designation online through the Benefits Connection website at [hr2.chevron.com](http://hr2.chevron.com), choose Personal Information link, then Beneficiaries.

## Changing Your Beneficiary

Because family situations can change, you may want to review your beneficiary designations from time to time. You may change your beneficiary at any time. (See above information about how to name a beneficiary)

## How Much You Pay for Coverage

Chevron currently pays the full cost of your retiree life insurance coverage described here, other than the Supplemental Life Insurance Plan for former Chevron employees.

### Note

The Internal Revenue Service (IRS) requires Chevron to report "imputed income" for all life insurance plans paid for by the company. An individual retiree's imputed income equals the estimated cost of the retiree's life insurance coverage in excess of \$50,000 (under plans paid for by Chevron). (The "value" of the retiree's imputed income is then determined using a table provided by the IRS.) Chevron will send you a W-2 form soon after the end of each year, showing the taxable value of your imputed income for the prior year. You must include this figure when you file your federal tax return. If you're disabled, you may not be required to pay income taxes on this "imputed income."

## When Coverage Ends

Retiree coverage under the Basic Life Insurance Plan continues until you die or until the plan or insurance contract on which it's based terminates. Supplemental Life Insurance coverage will continue as long as you pay the employee premium rate. Coverage may be canceled if you commit a dishonest act that causes loss of money or property to the company or to any organization whose membership is limited principally to Chevron employees or to Chevron employees and their families, regardless of your length of service or whether retirement benefits have been paid to you.

## **Re-employment**

If you are re-employed as a benefits-eligible employee on or after July 1, 2002, you will be treated as an active employee, not as a retiree, for all Chevron benefit plans, and your retiree life insurance coverage will be terminated. When you retire again, you will not be eligible for retiree life insurance coverage.

## **Converting Your Coverage**

If your Basic Life Insurance coverage is reduced or you terminate Supplemental Life Insurance coverage, you can convert the amount of the reduction to an individual whole life policy. Call the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.) to request a *Notice of Conversion Rights (F-54)* form. The form will provide verification of the amount of insurance you can convert. You will need this information when you contact MetLife. You must contact MetLife at 1-877-ASK-MET7 (1-877-275-6387) within 31 days after your coverage is reduced or terminated. Regardless of whether you apply for an individual policy, if you should die within the 31-day conversion period, the insurer will pay your beneficiary the full amount of your life insurance coverage in effect under this plan immediately before the date of your retirement or date of death, whichever comes first.

# How Much the Plan Pays

Your coverage equals:

$$\frac{\text{Your annualized regular pay at retirement divided by 24 times}}{\text{Your years of health and welfare eligibility service (up to 24 years) minus 15 percent per year for five years after you retire.}}$$

Your coverage is also reduced by 15 percent for each full year (up to five years) that you worked beyond your normal retirement date. However, your coverage will never drop below three months' pay.

## Example

Here's how coverage is reduced for an individual who retires at age 63 with coverage of \$48,000.

	Age	Percentage of Coverage at Retirement	Amount of Coverage
Retirement Date	63	100%	\$48,000
First Anniversary	64	85%	\$40,800
Second Anniversary	65	70%	\$33,600
Third Anniversary	66	55%	\$26,400
Fourth Anniversary	67	40%	\$19,200
Fifth Anniversary	68	25%	\$12,000

Note: Coverage will never be reduced to less than three months' regular pay.

### Annualized Regular Pay

Chevron annualizes your regular pay to determine your life insurance coverage amount. Your annualized regular pay is calculated as follows, depending on how you were paid while an employee:

- If you were paid an annual salary, your salary amount will be your annualized regular pay.
- If you were paid weekly or hourly, your annualized regular pay will be determined by multiplying your base rate of pay by the annual number of weeks or hours in your regular work schedule and adding shift differentials, if any.

Your annualized regular pay for retiree life insurance benefits is based on your pay in effect at the time of your retirement. Chevron, in its sole discretion, determines your regular work schedule and your annualized regular pay. Its determination is conclusive and binding. If you want to know what your current annualized regular pay is, contact the HR Service Center.



## When Benefits Are Paid

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Life insurance benefits are payable following your death. Your beneficiary must file a claim for benefits, as explained earlier.

### Accelerated Benefit Option

If you're covered under the Basic Life Insurance Plan for retirees and you're terminally ill, you can request accelerated payment of plan benefits if both of the following apply to you:

- Your doctor determines that you're terminally ill and expects you'll die within 12 months or in accordance with applicable state law requirements (contact MetLife for more information).
- Your plan coverage equals \$20,000 or more.

If your request is approved, you receive a lump-sum benefit equal to 80 percent of your coverage amount (up to a maximum benefit of \$500,000). Your beneficiary will receive the remaining amount of your coverage when you die.

The accelerated benefit option isn't available if you've assigned your coverage to another person or to an organization, if you're in the process of getting a divorce, or if you've already received an accelerated benefit option from this plan.

If you receive an accelerated benefit option under this plan, the benefit payable at your death is reduced by the amount of the accelerated benefit option. See [Requesting an Accelerated Benefit Option under How to File a Life Insurance Claim](#) for information about how to request an accelerated benefit option.

## How Benefits Are Paid

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Benefits are normally paid in a lump sum to your beneficiary, or to you in the case of an accelerated benefit option.

### **If You Haven't Named a Beneficiary**

If you don't designate a beneficiary, or if your beneficiary dies before you do, the plans pay benefits according to the standard succession of beneficiaries as follows:

- Your spouse/domestic partner; or, if none,
- Your surviving natural born and/or legally adopted children (in equal shares) or, if none,
- Your mother/father then living (in equal shares); or, if none,
- Your sisters and brothers then living (in equal shares); or if none,
- Your estate.

Benefits will only be paid to children who are born before your death.

See How to File a Life Insurance Claim for an explanation of how to file a claim for Chevron-paid life insurance plan benefits.

## Assigning Your Coverage

You can make a gift of your Basic Life Insurance Plan coverage to one or more people or to an organization that serves as a trustee, such as a bank or law firm.

When you do this, the person or organization that receives the gift — “the assignee” — becomes the owner of your coverage and has the right to change the beneficiary designation and to convert all or part of the coverage to an individual whole life policy if your coverage ends or is reduced. In addition, if you assign your coverage, you can’t request an accelerated benefit option. You cannot assign your life insurance as collateral for a loan.

If you want to assign your coverage — for instance, for estate planning purposes — contact the HR Service Center for more information or to request the forms you need to fill out.

### **Note**

The decision to assign your coverage is irrevocable. You can’t regain control of the coverage without your assignee’s agreement. This raises many important personal and legal issues and has tax implications. If you’re considering assigning your coverage, you should first consult with your attorney.

## Situations That Could Affect Your Benefit

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- If required by law or a court order, a portion of your benefit could be paid to someone other than your designated beneficiary.
- If you assign your coverage as explained above, your “assignee” becomes the owner of the coverage and has all of your former rights — including the right to name a beneficiary to receive plan benefits. You can't request an accelerated benefit option once you've assigned your coverage.

# Claims and Appeals

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Your beneficiary should contact the HR Service Center to file a claim for life insurance plan benefits. You should contact the HR Service Center if you want to request an accelerated benefit option. If your dispute concerns eligibility to participate in the plan, you must follow the procedures described in the How to File a Claim for Eligibility chapter of this summary plan description.

## Requesting an Accelerated Benefit Option

When you contact the HR Service Center, a Customer Service Representative verifies your coverage and contacts MetLife, Chevron's claims administrator, for you. MetLife sends you a package of information, including forms you and your doctor must complete. Your doctor must certify that you're expected to die within 12 months. The plans don't cover the cost of your doctor's visit.

## Claiming Benefits

When notified of your death, the HR Service Center Customer Service Representative will ask for the following information:

- Your name and Social Security number.
- The date of your death.
- The caller's name, address, telephone number, and relationship to you.
- If you die and you're married, your spouse's name, address, Social Security number and birth date.

The HR Service Center will send a package of information and forms to your beneficiary. Once the forms are completed and returned to the HR Service Center, they're sent to MetLife, Chevron's claims administrator, for payment.

Under normal circumstances, MetLife sends your beneficiary written notice of its decision on the claim within 90 days after receiving the completed claim form. Sometimes, because of special circumstances, more time is needed. If this is the case, the determination period can be extended for up to an additional 90 days. Your beneficiary must be notified of the reason for the delay before the original 90-day period expires. Your beneficiary must also be given a date as to when MetLife expects to make a decision.

You or your beneficiary can appeal a denied claim. See the following section for details regarding the claims appeals process.

## Appeals Procedures

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

- Reasons upon which the denial is based.
- Specific plan provision(s) upon which the denial is based.
- Request for additional material or information that's needed to complete your claim and an explanation of why such information is necessary.

- The plan's appeals procedures and the time limits that apply to them (including a statement of your right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

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

If a claim for benefits is denied (in whole or in part), you or your beneficiary can appeal the denial (in writing) within 90 days after receipt of the claims administrator's written notice that your claim is denied.

The claims administrator may require you or your beneficiary to submit (at your expense) additional information, documents, doctors' statements or other material necessary for the review.

**To appeal the denial of a life insurance claim, write to:**

Metropolitan Life Insurance Company  
Group Life Claims  
P.O. Box 6100  
Scranton, PA 18505

Overnight address:

Metropolitan Life Insurance Company  
Group Life Claims  
123 Wyoming Avenue  
Scranton, PA 18503  
1-800-638-6420  
5 a.m. to 5 p.m. Pacific time, Monday through Friday

In addition, claims can also be faxed to MetLife (570)558 8645.

As part of the appeals procedures, you or your beneficiary can:

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

The claims administrator reviews the claim and takes into account all relevant comments, documents, records and other information (without regard to whether such information was submitted or considered in the initial benefit determination). The claims administrator provides you with a written response to the appeal and does one of the following:

- Reverses the earlier decision and pays the part of the claim that was initially denied.
- Confirms the denial.

The claims administrator reviews and decides the appeal within 60 days after you or your beneficiary files the appeal request. If, because of special circumstances, the claims administrator can't reach a decision within 60 days, the review period can be extended for up to an additional 60 days. You or your beneficiary

must receive notice of the reason for the delay before the original 60-day period expires. You or your beneficiary must also receive a date as to when the claims administrator expects to make a decision. Once a decision on the appeal is reached, you or your beneficiary is notified in writing.

If the appeal is denied, the notice states the reasons for the denial and includes references to the specific plan provisions upon which the denial is based. It also includes a statement of your or your beneficiary's right to bring a civil action under section 502(a) of ERISA. For details, see Your ERISA Rights.

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

If the claims administrator fails to notify you or your beneficiary of its decision on your appeal within 60 days after the filing of the appeal (or within 120 days after filing of the appeal if you're notified of the 60-day extension), you or your beneficiary should consider the appeal deemed to be denied.

### **Administrative Power and Responsibilities**

Chevron Corporation has the discretionary authority to control and manage the operation and administration of 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.

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# Term Life Insurance Plan of Texaco, Inc. (For Former Texaco Employees)

This section describes the Chevron life insurance plans in effect for the former Texaco employee grandfathered group. This plan pays benefits in the event of your death. The amount of coverage provided by the plan depends on several factors, including the amount of your pay and your age at retirement. *If you are a former Unocal employee and you retired or left Unocal or Chevron before July 1, 2006, other benefit plan provisions may apply to you.*

- MetLife
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## Eligibility

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If you are a grandfathered former Texaco employee, you're eligible for coverage under the Former Texaco Term Life Insurance Plan if you meet all of the following requirements:

- You were an active Texaco employee age 45 or older on October 1, 1999, and elected to keep coverage under the former Term Life Insurance Plan of Texaco Inc.; **and**
- You retire under the Retirement Plan at or after age 50 with at least 10 years of health and welfare eligibility service and you have not been rehired since July 1, 2002; **or**
- You qualify for benefits under the Texaco Separation Pay Plan.

### **Health and Welfare Eligibility Service (HWES)**

Your health and welfare eligibility service is used to determine your eligibility for retiree health care benefits. For more information about HWES, see the Company Contributions to Medical Coverage Supplement included in this summary plan description.

# Participation

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If you meet the eligibility requirements, retiree life insurance coverage is automatic when you retire.

## Naming a Beneficiary

If you haven't already done so, you should name a beneficiary to receive any benefits that may be payable in the event of your death.

You can name more than one person as your beneficiary and they will share the life insurance benefit. If you name more than one beneficiary, be sure to designate what percentage of the entire benefit should be paid to each. The total must equal 100 percent. You also need to indicate the beneficiaries' relationship to you.

You can complete a *Designation of Beneficiary for Benefit Plans for Former Employees (F-73)* form. To request a form contact the HR Service Center at 1-888-825-5247 or (610-669-8595 outside the U.S.). You may also update your beneficiary designation online through the Benefits Connection website at [hr2.chevron.com](http://hr2.chevron.com), choose Personal Information link, then Beneficiaries.

## Changing Your Beneficiary

Because family situations can change, you may want to review your beneficiary designations from time to time. You may change your beneficiary at any time. (See above information about how to name a beneficiary)

## How Much You Pay for Coverage

Chevron currently pays the full cost of your retiree life insurance coverage described here.

### Note

The Internal Revenue Service (IRS) requires Chevron to report "imputed income" for all life insurance plans paid for by the company. An individual retiree's imputed income equals the estimated cost of the retiree's life insurance coverage in excess of \$50,000 (under plans paid for by Chevron). (The "value" of the retiree's imputed income is then determined using a table provided by the IRS.) Chevron will send you a W-2 form soon after the end of each year, showing the taxable value of your imputed income for the prior year. You must include this figure when you file your federal tax return. If you're disabled, you may not be required to pay income taxes on this "imputed income."

## When Coverage Ends

Retiree coverage under the Term Life Insurance Plan of Texaco, Inc. continues until you die or until the plan or insurance contract on which it's based terminates. Coverage may be canceled if you commit a dishonest act that causes loss of money or property to the company or to any organization whose membership is limited principally to Chevron employees or to Chevron employees and their families, regardless of your length of service or whether retirement benefits have been paid to you.

## **Re-employment**

If you are re-employed as a benefits-eligible employee on or after July 1, 2002, you will be treated as an active employee, not as a retiree, for all Chevron benefit plans, and your retiree life insurance coverage will be terminated. When you retire again, you will not be eligible for retiree life insurance coverage.

## **Converting Your Coverage**

If your Term Life Insurance Plan of Texaco, Inc Insurance coverage is reduced, you can convert the amount of the reduction to an individual whole life policy. Call the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.) to request a *Notice of Conversion Rights (F-54)* form. The form will provide verification of the amount of insurance you can convert. You will need this information when you contact MetLife. You must contact MetLife at 1-877-ASK-MET7 (1-877-275-6387) within 31 days after your coverage is reduced or terminated. Regardless of whether you apply for an individual policy, if you should die within the 31-day conversion period, the insurer will pay your beneficiary the full amount of your life insurance coverage in effect under this plan immediately before the date of your retirement or your date of death whichever is later.

## How Much the Plan Pays

If you elected to keep coverage under the Term Life Insurance Plan of Texaco, Inc. you remain eligible for reduced life insurance benefits under the plan upon your retirement. The amount of your retiree life insurance coverage depends on several factors, including your pay in effect on August 1, 2000, your age at retirement, and your status as a contributory member in the plan.

To qualify for **contributory coverage** at retirement, you must have been a contributory member for:

- Five years immediately preceding your retirement; or
- From the date you became eligible for the plan until your retirement date, if that period of time is less than five years.

You qualify for **noncontributory coverage** if you always were a noncontributory member of the plan or were not a contributory member for the qualifying period before your retirement.

After the initial reduction in your coverage at retirement, the amount of your life insurance coverage decreases each year beginning at age 66 and continues to decrease until you reach age 70. From age 70 on, the amount of your life insurance coverage remains unchanged.

The following charts show the amount of “normal” retiree life insurance provided by the plan.

<b>Contributory Coverage at Retirement</b>	
<b>Retiree's Age</b>	<b>Life Insurance Coverage (multiple of pay as of August 1, 2000)</b>
55 through 65	1.50
66	1.35
67	1.20
68	1.05
69	0.90
70 or older	0.75
<b>Noncontributory Coverage at Retirement</b>	
<b>Retiree's Age</b>	<b>Life Insurance Coverage (multiple of pay as of August 1, 2000)</b>
55 through 65	0.30
66	0.27
67	0.24
68	0.21
69	0.18
70 or older	0.15

**If you retire between ages 50 and 55 with at least 10 years of service:** The amount of your retiree life insurance is based on your base pay in effect on August 1, 2000, and your age at retirement. The amount of your normal retiree life insurance shown in the chart above will be reduced by 5 percent for each year you are under age 55, as shown in the chart below.

Retiree's Age	Percentage of Normal Retiree Life Insurance Coverage
50	75%
51	80%
52	85%
53	90%
54	95%

The percentage that applies to you, based on your age at retirement, will apply to you throughout your retirement. The percentage does not increase as you get older.

**Note:** This plan incorporates, by reference, the description of life insurance benefits contained in the Separation Pay Plan of Texaco Inc. Although the Separation Pay Plan of Texaco Inc. contains the description of certain additional life insurance benefits for those who qualify for severance pay under the Separation Pay Plan's Change of Control provisions, those additional life insurance benefits are actually provided under this plan rather than the Separation Pay Plan.

# When Benefits Are Paid

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Life insurance benefits are payable following your death. Your beneficiary must file a claim for benefits.

## Accelerated Benefit Option

If you're covered under the Term Life Insurance Plan of Texaco, Inc. and you're terminally ill, you can request accelerated payment of plan benefits if both of the following apply to you:

- Your doctor determines that you're terminally ill and expects you'll die within 12 months or in accordance with applicable state law requirements (contact MetLife for more information).
- Your plan coverage equals \$20,000 or more.

If your request is approved, you receive a lump-sum benefit equal to 80 percent of your coverage amount (up to a maximum benefit of \$500,000). Your beneficiary will receive the remaining amount of your coverage when you die.

The accelerated benefit option isn't available if you've assigned your coverage to another person or to an organization, if you're in the process of getting a divorce, or if you've already received an accelerated benefit option from this plan.

If you receive an accelerated benefit option under this plan, the benefit payable at your death is reduced by the amount of the accelerated benefit option. See [Requesting an Accelerated Benefit Option under How to File a Life Insurance Claim](#) for information about how to request an accelerated benefit option.

# How Benefits Are Paid

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Benefits are normally paid in a lump sum to your beneficiary or to you in the case of an accelerated benefit option.

## If You Haven't Named a Beneficiary

If you don't designate a beneficiary, or if your beneficiary dies before you do, the plans pay benefits according to the standard succession of beneficiaries as follows:

- Your spouse/domestic partner; or, if none,
- Your surviving natural born and/or legally adopted children (in equal shares) or, if none,
- Your mother/father then living (in equal shares) or, if none,
- Your sisters and brothers then living (in equal shares); or if none,
- Your estate

Benefits will only be paid to children who are born before your death.

See [How to File a Life Insurance Claim](#) for an explanation of how to file a claim for Chevron-paid life insurance plan benefits.

## Assigning Your Coverage

You can make a gift of your Term Life Insurance Plan of Texaco, Inc. coverage to one or more people or to an organization that serves as a trustee, such as a bank or law firm.

When you do this, the person or organization that receives the gift — “the assignee” — becomes the owner of your coverage and has the right to change the beneficiary designation and to convert all or part of the coverage to an individual whole life policy if your coverage ends or is reduced. In addition, if you assign your coverage, you can't request an accelerated benefit option. You cannot assign your life insurance as collateral for a loan.

If you want to assign your coverage — for instance, for estate planning purposes — contact the HR Service Center for more information or to request the forms you need to fill out.

### Note

The decision to assign your coverage is irrevocable. You can't regain control of the coverage without your assignee's agreement. This raises many important personal and legal issues and has tax implications. If you're considering assigning your coverage, you should first consult with your attorney.

## Situations That Could Affect Your Benefit

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- If required by law or a court order, a portion of your benefit could be paid to someone other than your designated beneficiary.
- If you assign your coverage as explained above, your “assignee” becomes the owner of the coverage and has all of your former rights — including the right to name a beneficiary to receive plan benefits. You can’t request an accelerated benefit option once you’ve assigned your coverage.



# Claims and Appeals

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Your Beneficiary Should Contact The HR Service Center To File A Claim For Life Insurance Plan Benefits.

You should contact the HR Service Center if you want to request an accelerated benefit option. If your dispute concerns eligibility to participate in the plan, you must follow the procedures described in the How to File a Claim for Eligibility chapter of this summary plan description.

## Requesting an Accelerated Benefit Option

When you contact the HR Service Center, a Customer Service Representative verifies your coverage and contacts MetLife, Chevron's claims administrator, for you. MetLife sends you a package of information, including forms you and your doctor must complete. Your doctor must certify that you're expected to die within 12 months. The plans don't cover the cost of your doctor's visit.

## Claiming Benefits

When notified of your death, the HR Service Center Customer Service Representative will ask for the following information:

- Your name and Social Security number.
- The date of your death.
- The caller's name, address, telephone number, and relationship to you.
- If you die and you're married, your spouse's name, address, Social Security number and birth date.
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The HR Service Center will send a package of information and forms to your beneficiary. Once the forms are completed and returned to the HR Service Center, they're sent to MetLife, Chevron's claims administrator, for payment.

Under normal circumstances, MetLife sends your beneficiary written notice of its decision on the claim within 90 days after receiving the completed claim form. Sometimes, because of special circumstances, more time is needed. If this is the case, the determination period can be extended for up to an additional 90 days. Your beneficiary must be notified of the reason for the delay before the original 90-day period expires. Your beneficiary must also be given a date as to when MetLife expects to make a decision.

If MetLife doesn't notify your beneficiary of its decision within 90 days after the claim is filed (or within 180 days if there's a 90-day extension), consider the claim denied. Your beneficiary can appeal a denied claim. See the following section for details regarding the claims appeals process.

## Appeals Procedures

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

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

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

The claims administrator may require you or your beneficiary to submit (at your expense) additional information, documents, doctors' statements or other material necessary for the review.

### **To appeal the denial of a life insurance claim, write to:**

Metropolitan Life Insurance Company  
Group Life Claims  
P.O. Box 6100  
Scranton, PA 18505

Overnight address:

Metropolitan Life Insurance Company  
Group Life Claims  
123 Wyoming Avenue  
Scranton, PA 18503  
1-800-638-6420  
5 a.m. to 5 p.m. Pacific time, Monday through Friday

In addition, claims can also be faxed to MetLife (570)558 8645.

As part of the appeals procedures, you or your beneficiary can:

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

The claims administrator reviews the claim and takes into account all relevant comments, documents, records and other information (without regard to whether such information was submitted or considered in the initial benefit determination). The claims administrator provides you with a written response to the appeal and does one of the following:

- Reverses the earlier decision and pays the part of the claim that was initially denied;
- Confirms the denial.

The claims administrator reviews and decides the appeal within 60 days after you or your beneficiary files the appeal request. If, because of special circumstances, the claims administrator can't reach a decision within 60 days, the review period can be extended for up to an additional 60 days. You or your beneficiary must receive notice of the reason for the delay before the original 60-day period expires. You or your beneficiary must also receive a date as to when the claims administrator expects to make a decision. Once a decision on the appeal is reached, you or your beneficiary is notified in writing.

If the appeal is denied, the notice states the reasons for the denial and includes references to the specific plan provisions upon which the denial is based. It also includes a statement of your or your beneficiary's right to bring a civil action under section 502(a) of ERISA. For details, see Your ERISA Rights.

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

## **Administrative Power and Responsibilities**

Chevron Corporation has the discretionary authority to control and manage the operation and administration of 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.

# Unocal Life Insurance Plan (For Former Unocal Employees)

This section describes the Chevron life insurance plans in effect for the former Unocal employee grandfathered group. This plan pays benefits in the event of your death. *If you are a former Unocal employee and you retired or left Unocal or Chevron before July 1, 2006, other benefit plan provisions may apply to you. If you are a former Texaco employee and you retired or left Texaco before July 1, 2002, other benefit plan provisions may apply to you.*

- MetLife

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**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.**

# Eligibility

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If you are a former Unocal employee who retires after July 1, 2006, and before December 31, 2007, you are eligible for the Grandfathered Unocal Basic Life Insurance benefit if you meet both the following requirements:

- You must be age 55 or older with 10 or more years of health and welfare eligibility service when you retire.
- You must retire after July 1, 2006, and before December 31, 2007.

## **Health and Welfare Eligibility Service (HWES)**

Your health and welfare eligibility service is used to determine your eligibility for retiree health care benefits. For more information about HWES, see the Company Contributions to Medical Coverage Supplement included in this summary plan description.

# Participation

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If you meet the eligibility requirements, retiree life insurance coverage is automatic when you retire.

## **Naming a Beneficiary**

If you haven't already done so, you should name a beneficiary to receive any benefits that may be payable in the event of your death.

You can name more than one person as your beneficiary and they will share the life insurance benefit. If you name more than one beneficiary, be sure to designate what percentage of the entire benefit should be paid to each. The total must equal 100 percent. You also need to indicate the beneficiaries' relationship to you.

You can complete a *Designation of Beneficiary for Benefit Plans for Former Employees (F-73)* form. To request a form contact the HR Service Center at 1-888-825-5247 or (610-669-8595 outside the U.S.). You may also update your beneficiary designation online through the Benefits Connection website at [hr2.chevron.com](http://hr2.chevron.com), choose Personal Information link, then Beneficiaries.

## Changing Your Beneficiary

Because family situations can change, you may want to review your beneficiary designations from time to time. You may change your beneficiary at any time. (See above information about how to name a beneficiary)

## **How Much You Pay for Coverage**

Chevron pays the full cost of your retiree life insurance coverage described here, other than the Supplemental Life Insurance Plan for former Chevron employees.

### **Note**

The Internal Revenue Service (IRS) requires Chevron to report "imputed income" for all life insurance plans paid for by the company. An individual retiree's imputed income equals the estimated cost of the retiree's life insurance coverage in excess of \$50,000 (under plans paid for by Chevron). (The "value" of the retiree's imputed income is then determined using a table provided by the IRS.) Chevron will send you a W-2 form soon after the end of each year, showing the taxable value of your imputed income for the prior year. You must include this figure when you file your federal tax return. If you're disabled, you may not be required to pay income taxes on this "imputed income."

## **When Coverage Ends**

Retiree coverage under the Basic Life Insurance Plan continues until you die or until the plan or insurance contract on which it's based terminates. Supplemental Life Insurance coverage will continue as long as you pay the employee premium rate. Coverage may be canceled if you commit a dishonest act that causes loss of money or property to the company or to any organization whose membership is limited principally to Chevron employees or to Chevron employees and their families, regardless of your length of service or whether retirement benefits have been paid to you.

## **Re-employment**

If you are re-employed as a benefits-eligible employee after July 1, 2006, you will be treated as an active employee, not as a retiree, for all of Chevron benefit plans, and your retiree life insurance coverage will be terminated. When you retire again, you will not be eligible for retiree life insurance coverage.

## How Much the Plan Pays

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If you are eligible for the Unocal Life Insurance Plan, your basic life insurance coverage equals \$5,000. This coverage continues at no cost to you. Life insurance benefits are payable following your death. Your beneficiary must file a claim for benefits.

### **Accelerated Benefit Option**

If you're covered under the Unocal Life Insurance Plan, and your benefit amount is at least \$10,000 and you're terminally ill, you can request accelerated payment of plan benefits if your doctor determines that you're terminally ill and expects you'll die within 12 months or in accordance with applicable state law requirements (contact MetLife for more information).

If your request is approved, you receive a lump-sum benefit equal to 80 percent of your coverage amount. Your beneficiary will receive the remaining amount of your coverage when you die.

The accelerated benefit option isn't available if you've assigned your coverage to another person or to an organization, if you're in the process of getting a divorce, or if you've already received an accelerated benefit option from this plan.

If you receive an accelerated benefit option under this plan, the benefit payable at your death is reduced by the amount of the accelerated benefit option. See [Requesting an Accelerated Benefit Option](#) under [How to File a Life Insurance Claim](#) for information about how to request an accelerated benefit option.



## How Benefits Are Paid

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Benefits are normally paid in a lump sum to your beneficiary, or to you in the case of an accelerated benefit option.

### **If You Haven't Named a Beneficiary**

If you don't designate a beneficiary, or if your beneficiary dies before you do, the plans pay benefits according to the standard succession of beneficiaries as follows:

- Your spouse/domestic partner; or, if none,
- Your surviving natural born and/or legally adopted children (in equal shares); or, if none,
- Your mother/father then living (in equal shares); or, if none,
- Your sisters and brothers then living (in equal shares); or if none,
- Your estate.

Benefits will only be paid to children who are born before your death.

## Assigning Your Coverage

You can make a gift of your Grandfathered Unocal Basic Life Insurance Plan coverage to one or more people or to an organization that serves as a trustee, such as a bank or law firm.

When you do this, the person or organization that receives the gift — “the assignee” — becomes the owner of your coverage and has the right to change the beneficiary designation and to convert all or part of the coverage to an individual whole life policy if your coverage ends or is reduced. In addition, if you assign your coverage, you can’t request an accelerated benefit option. You cannot assign your life insurance as collateral for a loan.

If you want to assign your coverage — for instance, for estate planning purposes — contact the HR Service Center for more information or to request the forms you need to fill out.

### **Note**

The decision to assign your coverage is irrevocable. You can't regain control of the coverage without your assignee's agreement. This raises many important personal and legal issues and has tax implications. If you're considering assigning your coverage, you should first consult with your attorney.

## Situations That Could Affect Your Benefit

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- If required by law or a court order, a portion of your benefit could be paid to someone other than your designated beneficiary.
- If you assign your coverage as explained above, your “assignee” becomes the owner of the coverage and has all of your former rights — including the right to name a beneficiary to receive plan benefits. You can't request an accelerated benefit option once you've assigned your coverage.

# Claims and Appeals

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Your beneficiary should contact the HR Service Center to file a claim for life insurance plan benefits. You should contact the HR Service Center if you want to request an accelerated benefit option. If your dispute concerns eligibility to participate in the plan, you must follow the procedures described in the How to File a Claim for Eligibility chapter of this summary plan description.

## Requesting an Accelerated Benefit Option

When you contact the HR Service Center, a Customer Service Representative verifies your coverage and contacts MetLife, Chevron's claims administrator, for you. MetLife sends you a package of information, including forms you and your doctor must complete. Your doctor must certify that you're expected to die within 12 months. The plans don't cover the cost of your doctor's visit.

## Claiming Benefits

When notified of your death, the HR Service Center Customer Service Representative will ask for the following information:

- Your name and Social Security number.
- The date of your death.
- The caller's name, address, telephone number, and relationship to you.
- If you die and you're married, your spouse's name, address, Social Security number and birth date.

The HR Service Center will send a package of information and forms to your beneficiary. Once the forms are completed and returned to the HR Service Center, they're sent to MetLife, Chevron's claims administrator, for payment.

Under normal circumstances, MetLife sends your beneficiary written notice of its decision on the claim within 90 days after receiving the completed claim form. Sometimes, because of special circumstances, more time is needed. If this is the case, the determination period can be extended for up to an additional 90 days. Your beneficiary must be notified of the reason for the delay before the original 90-day period expires. Your beneficiary must also be given a date as to when MetLife expects to make a decision.

If MetLife doesn't notify your beneficiary of its decision within 90 days after the claim is filed (or within 180 days if there's a 90-day extension), consider the claim denied. Your beneficiary can appeal a denied claim. See the following section for details regarding the claims appeals process.

## Appeals Procedures

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

- Reasons upon which the denial is based.
- Specific plan provision(s) upon which the denial is based.
- Request for additional material or information that's needed to complete your claim and an explanation of why such information is necessary.
- The plan's appeals procedures and the time limits that apply to them (including a statement of your right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) following an adverse decision on review.

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

If a claim for benefits is denied (in whole or in part), you or your beneficiary can appeal the denial (in writing) within 90 days after receipt of the claims administrator's written notice that your claim is denied.

The claims administrator may require you or your beneficiary to submit (at your expense) additional information, documents, doctors' statements or other material necessary for the review.

### **To appeal the denial of a life insurance claim, write to:**

Metropolitan Life Insurance Company  
Group Life Claims  
P.O. Box 6100  
Scranton, PA 18505

Overnight address:

Metropolitan Life Insurance Company  
Group Life Claims  
123 Wyoming Avenue  
Scranton, PA 18503

1-800-638-6420

5 a.m. to 5 p.m. Pacific time, Monday through Friday

In addition, claims can also be faxed to MetLife (570)558 8645.

As part of the appeals procedures, you or your beneficiary can:

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

The claims administrator reviews the claim and takes into account all relevant comments, documents, records and other information (without regard to whether such information was submitted or considered in the initial benefit determination). The claims administrator provides you with a written response to the appeal and does one of the following:

- Reverses the earlier decision and pays the part of the claim that was initially denied.
- Confirms the denial.

The claims administrator reviews and decides the appeal within 60 days after you or your beneficiary files the appeal request. If, because of special circumstances, the claims administrator can't reach a decision within 60 days, the review period can be extended for up to an additional 60 days. You or your beneficiary must receive notice of the reason for the delay before the original 60-day period expires. You or your beneficiary must also receive a date as to when the claims administrator expects to make a decision. Once a decision on the appeal is reached, you or your beneficiary is notified in writing.

If the appeal is denied, the notice states the reasons for the denial and includes references to the specific plan provisions upon which the denial is based. It also includes a statement of your or your beneficiary's right to bring a civil action under section 502(a) of ERISA. For details, see Your ERISA Rights.

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

## **Administrative Power and Responsibilities**

Chevron Corporation has the discretionary authority to control and manage the operation and administration of 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.



# COBRA and Continuation 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.

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**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.**



# Introduction

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

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

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

## What Is Continuation Coverage?

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

You, your spouse and your dependent children could become qualified beneficiaries if coverage under a Chevron health plan is lost because of the qualifying event. Qualified beneficiaries also include any children born to you or adopted or placed for adoption with you during the continuation coverage period. Pursuant to Chevron policy, domestic partners and domestic partner dependent children who are covered under a Chevron health plan on the day before a qualifying event are also permitted to elect continuation coverage that is similar to COBRA. You do not have to show that you are insurable to choose continuation coverage. However, you will have to pay the total premium for your continuation coverage, plus a 2 percent administration fee.

## Conversion Coverage

If you are enrolled in an insured plan or HMO and you elect continuation coverage, you may have an option to convert your health coverage to an individual policy at the termination of your continuation coverage. Contact your insurer or HMO for additional information about any conversion rights you may have. There are no conversion rights for 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?

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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

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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 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

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## **Chevron Must Give Notice of Some Events**

Chevron has the responsibility to notify ADP Benefit Services, which handles Chevron's continuation coverage administration, when your Chevron employment ends for any reason other than termination for gross misconduct.

## **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 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 you 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 retired 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 retirees 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

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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 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

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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 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. 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/domestic partner and your covered dependents may qualify for up to 18 months of health care continuation coverage if you qualify because your Chevron employment ends for any reason other than termination for gross misconduct. Your covered spouse/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 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 the 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 as a dependent child under the terms of a Chevron health plan. 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

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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. Chevron Retiree and Survivor Coverage

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

- Retiree and survivor coverage.
- Continuation coverage.

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

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

- This provision does not apply if you were a former employee who terminated and who was eligible for both subsidized COBRA and retiree medical coverage and initially elected subsidized COBRA coverage. In this case you can immediately enroll in retiree medical coverage after your subsidized COBRA coverage ends provided you do so within 31 days of the subsidized COBRA coverage ending.
- This provision does not apply if you and your dependents are covered by another Group Health Plan (e.g. Another employer 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 who 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.

## **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, if applicable, his or her covered dependent(s)) coverage under Chevron's health plans terminates. In the event such survivor subsequently elects continuation coverage within the election period, such survivor's (and his or her eligible dependents, 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 if you commit fraud or make an 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.

## How to Contact ADP

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If you have any questions about the COBRA law, please contact ADP Benefit Services at 1-888-825-5247, option 2, then option 7. Or, write to ADP Benefit Services at P.O. Box 2638, Alpharetta, GA 30023-2638.



# How to File a Claim for Eligibility

This section provides information regarding eligibility to participate in the Omnibus Health Care Plan.

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**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.**

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.

## **Appeals Procedures for Denied Claims Regarding Eligibility to Participate or Credit for Health and Welfare Eligibility Service in the Omnibus Health Care Plan**

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.





# 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).

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**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.**

## Employer Identification Number (EIN)

The employer identification number is 94-0890210.

The employer identification number for the Unocal Life Insurance Plan is 95-1315450

## Plan Sponsor and Plan Administrator

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

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

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

### Chevron Corporation Omnibus Health Care Plan

**Plan number:** 560

**Type of Administration:** Contract Administration

**Type of Plan:** Health Plan

### Chevron Corporation Medical Plan

**(as Administered by UnitedHealthcare)**

(also referred to as: Chevron Medical Plan, Medical PPO, together with the Prescription Drug Program and basic vision coverage under the Vision Program)  
This plan is part of the Omnibus Health Care Plan.

**Plan number:** 560

**Claims Administrator:**

UnitedHealthcare Group Claims – Chevron | Group #247848 |  
P.O. Box 30555 | Salt Lake City, UT 84130-0555 | [www.myuhc.com](http://www.myuhc.com)

**Type of Administration:** Contract Administration

**Type of Plan:** Medical Benefit

### Chevron Medicare Plus Plan

**(as Administered by UnitedHealthcare)**

(also referred to as: Medicare Plus Plan, together with the Express Scripts Medicare™ (PDP) and basic vision coverage under the Vision Program) This plan is part of the Omnibus Health Care Plan.

**Plan number:** 560

**Claims Administrator:**

UnitedHealthcare Group Claims – Chevron | Group #247848 |  
P.O. Box 30555 | Salt Lake City, UT 84130-0555 | [www.myuhc.com](http://www.myuhc.com)

**Type of Administration:** Contract Administration

**Type of Plan:** Medical Benefit

**Chevron Medicare Standard Plan****(as Administered by UnitedHealthcare)**

(also referred to as: Medicare Standard Plan, together with the Express Scripts Medicare™ (PDP) and basic vision coverage under the Vision Program) This plan is part of the Omnibus Health Care Plan.

**Plan number:** 560

**Claims Administrator:**

UnitedHealthcare Group Claims – Chevron | Group #247848 |  
P.O. Box 30555 | Salt Lake City, UT 84130-0555 | [www.myuhc.com](http://www.myuhc.com)

**Type of Administration:** Contract Administration

**Type of Plan:** Medical Benefit

**Chevron Senior Care Plan****(as Administered by UnitedHealthcare)**

(also referred to as: Senior Care Plan, together with the Express Scripts Medicare™ (PDP) and basic vision coverage under the Vision Program) This plan is part of the Omnibus Health Care Plan.

**Plan number:** 560

**Claims Administrator:**

UnitedHealthcare Group Claims – Chevron | Group #247848 |  
P.O. Box 30555 | Salt Lake City, UT 84130-0555 | [www.myuhc.com](http://www.myuhc.com)

**Type of Administration:** Contract Administration

**Type of Plan:** Medical Benefit

**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

**Type of Plan:** Medical Benefit

**Chevron Corporation Prescription Drug Program**

This program is part of the Medical PPO and Omnibus Health Care Plan.

**Plan number:** 560

**Claims Administrator:**

Express Scripts | One Express Way | St. Louis, MO 63121 |

[www.Express Scripts.com](http://www.Express Scripts.com)

**Type of Administration:** Contract Administration

**Type of Plan:** Medical (Prescription Drug) Benefit

**Express Scripts Medicare™ (PDP)**

This program is part of the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, Chevron Senior Care Plan and Omnibus Health Care Plan.

**Plan number:** 560

**Claims Administrator:**

Express Scripts | One Express Way | St. Louis, MO 63121 |

[www.Express Scripts.com](http://www.Express Scripts.com)

**Type of Administration:** Contract Administration

**Type of Plan:** Medical (Prescription Drug) Benefit

**Chevron Corporation Vision Program**

A portion of this program is part of the Medical PPO, the Chevron Medicare Plus Plan, the Chevron Senior Care Plan, the Chevron Medicare Standard Plan and Omnibus Health Care Plan.

**Plan number:** 560

**Insurer:**

P.O. Box 997105 | Sacramento, CA 95899-7105 | [www.vsp.com](http://www.vsp.com)

**Type of Administration:** Insurer Administration

**Type of Plan:** Vision Benefit

**Chevron Corporation Mental Health and Substance Abuse Plan**

This plan is part of the Omnibus Health Care Plan.

**Plan number:** 560

**Claims Administrator:**

ValueOptions | P.O. Box 1290 | Latham, NY 12110 [www.valueoptions.com](http://www.valueoptions.com)

**Type of Administration:** Contract administration

**Type of Plan:** Mental Health and Substance Abuse Benefits

**Chevron Corporation Dental Plan**

(also referred to as the Dental PPO)

This plan is part of the Omnibus Health Care Plan.

**Plan number:** 560

**Claims Administrator:**

United Concordia Companies, Inc. | Dental Claims Department

P.O. Box 69420 | Harrisburg, PA 17106 | [www.ucci.com](http://www.ucci.com)

**Type of Administration:** Contract Administration

**Type of Plan:** Dental 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

**Type of Plan:** Dental Benefit

**Basic Life Insurance Plan (Former Chevron Employees)**

**Plan number:** 525

**Claims Administrator/Insurer:**

Claims: MetLife Group Life Claims | P.O. Box 6100 Scranton, PA 18505-6100

Statement of Health Unit | P.O. Box 14069 | Lexington, KY 40512-4069

**Type of Administration:** Insured

**Funding/Source of Contributions:** Funded by company contributions under a fully insured arrangement with the insurer.

**Type of Plan:** Life Insurance

**Unocal Life Insurance Plan (Former Unocal Employees)**

**Plan number:** 502

**Claims Administrator/Insurer:**

Claims: MetLife Group Life Claims | P.O. Box 6100 Scranton, PA 18505-6100

Statement of Health Unit | P.O. Box 14069 | Lexington, KY 40512-4069

**Type of Administration:** Insured

**Funding/Source of Contributions:** Funded by retiree and company contributions under a fully insured arrangement with the insurer.

**Type of Plan:** Life Insurance

**Term Life Insurance Plan of Texaco, Inc. (Former Texaco Employees)**

**Plan number:** 828

**Claims Administrator:** MetLife Group Life Claims |  
P.O. Box 6100 Scranton, PA 18505-6100

**Type of Administration:** Insurer

**Funding Method:** Funded by retiree and company contributions under a fully insured arrangement with the insurer.

**Type of Plan:** Insured welfare plan

**Chevron Corporation Life Insurance Plan for Individuals  
in Gulf Group Insurance Plan on June 30, 1986.**

**Plan number:** 699

**Claims Administrator/Insurer:**

Claims: MetLife Group Life Claims | P.O. Box 6100 Scranton, PA 18505-6100  
Statement of Health Unit: P.O. Box 14069 | Lexington, KY 40512-4069

**Type of Administration:** Insured

**Funding/Source of Contributions:** Funded by retiree and company contributions under a fully insured arrangement with the insurer.

**Type of Plan:** Life Insurance

**Supplemental Life Insurance Plan**

**Plan number:** 503

**Claims Administrator/Insurer:**

Claims: MetLife Group Life Claims | P.O. Box 6100 Scranton, PA 18505-6100  
Statement of Health Unit: P.O. Box 14069 | Lexington, KY 40512-4069

**Type of Administration:** Insured

**Funding/Source of Contributions:** Funded by retiree contributions under a fully insured arrangement with the insurer.

**Type of Plan:** Life Insurance

## **Agent for Service of Legal Process**

If you wish to take legal action after exhausting the claims and appeals procedures, legal process should be served on:

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

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

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.).

## **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 retirees are covered by each of the Chevron benefit plans can be obtained by writing to the plan administrator.

## **Incorrect Computation of Benefits**

If you believe the amount of the benefit you receive from the plans described in this booklet is incorrect, you should notify the appropriate claims administrator, in writing, at the address shown in the Summary Chart. If it's found that you or a beneficiary wasn't paid benefits you or your beneficiary was entitled to, the plan will pay the unpaid benefits. Similarly, if the calculation of your or your beneficiary's benefit results in an overpayment, you or your beneficiary will be required to repay the amount of the overpayment to the plan.



## Recovery of Overpayments

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

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

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

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

## Plan Year

The plan year for Chevron’s benefit plans described in this booklet begins on January 1 and ends on December 31 of each year.

## Future of the Plans

Chevron Corporation has 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. The rules that specify what happens when a plan is changed, terminated or merged vary from plan to plan, as shown below.

### Health Plans

Medical, dental or mental health and substance abuse claims incurred before the effective date of a plan change or termination won’t be affected. Claims incurred after a plan is terminated won’t be covered.

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

If all claims and expenses are paid and Chevron Corporation’s book reserve established for the purpose of making contributions toward the cost of retirees’ health care coverage retains a balance, Chevron Corporation will determine what to do with the excess amount in view of the purposes of the plans.

### **Life Insurance Plans**

Claims incurred before the date a retiree life insurance plan is changed or terminated won't be affected. Claims incurred after the date the plan is changed or terminated may not be covered.

If any of the life insurance plans are terminated and all plan benefits are paid, any other amounts will be returned to Chevron, including amounts that are payable under the group insurance contract.

### **Intentional Misrepresentations**

If you commit fraud or make an intentional misrepresentation of a material fact about your participation in the health care plans, the plans have 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, submitting falsified claims or covering a dependent who is ineligible (for instance, adding a spouse before you are married or after you are divorced, or adding a child who doesn't meet the plan qualifications of an eligible dependent).

### **Misconduct**

You may not be eligible for retiree coverage under any plans described here if you engaged in misconduct during the course of your employment with the company, whether or not the misconduct was discovered before or after your employment was terminated. Examples of misconduct include embezzlement from the company or its customers or suppliers; fraud against the company; deliberately disregarding the rules of the company, resulting in material loss; damage to property or injury to employees or others; and the unauthorized disclosure of company secrets or confidential information.

### **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.



# Third-Party Responsibility

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## **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 recover 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 agree 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.

# Other Legislation That Can Affect Your Benefits

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

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## **Newborns' and Mothers' Health Protection Act of 1996**

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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

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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 Medical Plan or HMO before any reconstructive surgery to make sure you qualify for full benefits.

## **Mental Health Parity Act of 1996**

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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)

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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

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This section is a notice regarding Medicaid and the Children's Health Insurance Program for purposes of medical, dental and vision coverage *only*.

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

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

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

## **If you have any questions**

Please call the HR Service Center 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.

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

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

<b>RHODE ISLAND – Medicaid</b>	<b>WASHINGTON – Medicaid</b>
Website: <a href="http://www.ohhs.ri.gov">www.ohhs.ri.gov</a> Phone: 401-462-5300	Website: <a href="http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm">http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm</a> Phone: 1-800-562-3022 ext. 15473
<b>SOUTH CAROLINA – Medicaid</b>	<b>WEST VIRGINIA – Medicaid</b>
Website: <a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a> Phone: 1-888-549-0820	Website: <a href="http://www.dhhr.wv.gov/bms/">www.dhhr.wv.gov/bms/</a> Phone: 1-877-598-5820, HMS Third Party Liability
<b>SOUTH DAKOTA - Medicaid</b>	<b>WISCONSIN – Medicaid</b>
Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a> Phone: 1-888-828-0059	Website: <a href="http://www.badgercareplus.org/pubs/p-10095.htm">http://www.badgercareplus.org/pubs/p-10095.htm</a> Phone: 1-800-362-3002
<b>TEXAS – Medicaid</b>	<b>WYOMING – Medicaid</b>
Website: <a href="https://www.gethiptexas.com/">https://www.gethiptexas.com/</a> Phone: 1-800-440-0493	Website: <a href="http://health.wyo.gov/healthcarefin/equalitycare">http://health.wyo.gov/healthcarefin/equalitycare</a> 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](http://www.dol.gov/ebsa)  
1-866-444-EBSA (3272)

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

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





# 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 Chevron Corporation benefit plans described in this booklet, you're entitled to certain rights and protections under ERISA.

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# Your ERISA Rights

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## 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 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.
- Request a personalized statement of your pension benefits.

## 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 of this summary plan description and the documents governing the plan.

### If You Have a Pre-existing Condition

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

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

You may request the certificate before losing coverage or up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. To request a certificate of creditable coverage, contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). Your personal identification number (PIN) will be required when making this request. Additionally, you can mail your request to the following address: 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

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If your claim for a 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 [Filing a Lawsuit](#) 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

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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](http://www.dol.gov/ebsa/publications/main.html).

# Filing a Lawsuit

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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 (if applicable to a health plan) 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 appeal 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 appeal).

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 a dental health maintenance organization (DHMO) regarding benefits of claims, 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.

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# Company Contributions to Retiree Medical Coverage

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

The Company Contributions for Retiree Health Coverage Supplement generally describes the Chevron Corporation Policy regarding its contribution to the cost of health 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

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## Benefits Connection Website

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

- [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree). 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 retirees on the U.S. Benefits website.

- [hr2.chevron.com/retiree](http://hr2.chevron.com/retiree)

# Company Contributions to Retiree Medical Coverage

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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**

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

# About Health and Welfare Eligibility Service

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## 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

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## **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.

## Retiree Dental Coverage: How the Company Contributes

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If you're eligible for retiree dental coverage, the company currently contributes a share of the total cost for premiums. In general, if you retired on or after July 1, 2002, and you were 50 years of age with 10 years or more of health and welfare eligibility service, including five years of health and welfare eligibility service since your last rehire date, you are eligible for retiree dental coverage. You may also be eligible under the grandfather rules described above. If you're eligible for dental coverage, the company's contribution to retiree dental coverage is based on a fixed dollar amount to each coverage tier and may change from time to time. The company reserves the right to change its dental contribution at any time. You pay the difference between the company's contribution and the total premium.



## **Retiree Mental Health and Substance Abuse Plan: How the Company Contributes**

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If you're eligible for retiree Mental Health and Substance Abuse (MHSA) Plan coverage, the company currently contributes 100 percent of the total cost for premiums. You pay no premiums. In general, to be covered under the Chevron MHSA Plan, you and your dependents must not be eligible for Medicare and must be enrolled in the Medical PPO plan offered by Chevron. The company reserves the right to change its MHSA contribution at any time.

## Health Benefits: Your Contributions

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



# Glossary

Here are some important terms related to your benefit plans.

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## **Allowable Charge (Medical PPO Plan)**

To be considered “allowable,” a charge must be within a range of charges billed by doctors or other providers for the same service or supply. Allowable charges may vary from one geographic area to another. Allowable charges are determined by the claims administrator (other than charges for vision care covered under the plan’s Vision Program or outpatient prescription drugs covered under the plan’s Prescription Drug Program). In the case of covered charges from a non-network provider who is affiliated with MultiPlan, allowable charge means the discounted rate.

The discounted rates charged by providers in the PPO network aren’t subject to the allowable charge provisions of the plan.

When reviewing charges to determine if they’re covered under the plan, the plan’s claims administrator doesn’t attempt to set the amount that doctors and other providers charge for needed services, nor does the claims administrator restrict your right to go to any doctor you choose.

## **Allowable Charge (Chevron Medicare Plus Plan, Chevron Medicare Standard Plan, Chevron Senior Care Plan)**

Allowable charge means an amount measured and determined by the claims administrator by comparing the actual charge for a service or supply with the prevailing charges made for it. The claims administrator, in its sole discretion, determines the prevailing charge, taking into account pertinent factors including, but not limited to:

- The Medicare-approved amount for such service.
- The complexity of the service.
- The range of services provided.
- The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.
- Allowable charges for prescription drug and vision will be determined separately (if applicable) by the claims administrators of the Medicare Prescription Plan and the Vision Program.

## **Allowance (Dental Plan)**

See UCCI’s Allowance (Dental Plan).

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## **Allowed Charges or Allowed Charge (Mental Health and Substance Abuse Plan)**

Allowed charges are the basis for reimbursements that the plan will pay for necessary services and supplies that are ordered by an out-of-network clinician (although not all treatment and services prescribed by a clinician are considered allowed charges) and that are covered by the plan. Allowed charges for those services and supplies may vary from one geographic area to another and are based on a range of rates and fees that most clinicians charge for the same service in that area and must be no more than the out-of-network clinician normally charges for the service or supply. When reviewing charges to determine if they're covered under the plan's out-of-network coverage, ValueOptions, the claims administrator, doesn't attempt to set the amount that nonparticipating clinicians charge for needed services, nor does ValueOptions restrict your right to go to any clinician you choose. However, ValueOptions does determine the allowed charge, and you're responsible for paying the difference between your nonparticipating clinician's charge and the allowed charge as established by ValueOptions.

## **Ambulatory Surgical Center**

- A specialized facility established, equipped, operated and staffed primarily for performing surgical procedures and that fully meets one of the following two tests:
- It is licensed as an ambulatory surgical center by the appropriate local regulatory authority.

Where licensing is not required, it meets *all* of the following requirements:

- It is operated under the supervision of a licensed doctor (M.D. or D.O.) who is devoting full time to supervision, and it permits a surgical procedure to be performed only by a doctor who has current privileges to perform the procedure in at least one area hospital.
- Except for cases requiring only local infiltration of anesthetics, it requires that a licensed anesthesiologist administer the anesthetic or supervise an anesthesiologist to administer the anesthetic. The anesthesiologist or anesthesiologist must remain present throughout the surgical procedure.
- It provides at least one operating room and at least one postanesthesia recovery room.
- It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services.
- It has immediate access to a blood bank or blood supplies.
- It has trained personnel and necessary equipment to handle emergency situations.
- It provides full-time services of registered nurses (R.N.) for patient care in the operating rooms and in the postanesthesia recovery room.
- It maintains an adequate medical record for each patient.
- An ambulatory surgical center can be a stand-alone facility or part of a hospital.

## **Annual Benefit Maximum (Dental PPO Plan)**

The maximum dollar amount the dental plan will pay toward the cost of covered charges for each covered member for the plan year.

The annual maximums for network and out of network coverage are combined: any network benefits used count toward the annual maximum for out-of-network benefits; any out-of-network benefits used count toward the annual maximum for network benefits.

## **Annual Deductible (Medical Plans and Dental PPO)**

The amount of certain covered charges you pay for combined network and out-of-network care and services each calendar year before each plan begins paying its share of those charges.

## **Annual Deductible (Medical PPO - Prescription Drug Program)**

The amount of covered prescription drug charges you pay for combined retail network and out-of-network services each calendar year before the plan begins paying its share of those charges.

## **Birthing Center**

A facility that provides a home-like setting under a controlled environment for the purpose of childbirth. These facilities legally operate under the license of a qualified hospital.

## **Brand-Name Drug**

A prescription drug that is *all* of the following:

- Manufactured and marketed under a trademark or a name given by a specific drug manufacturer.
- Typically protected under patent rights.
- Commonly acknowledged by pharmacies, drug companies and drug manufacturers as a brand-name drug.

## **Center of Excellence**

- UnitedHealthcare covers certain organ and tissue transplants if they are performed at a Center of Excellence. A Center of Excellence is one of several designated, well-known, highly respected hospitals throughout the country that have extensive experience with specific transplant operations.

## **Chevron's Employee Assistance and WorkLife Services**

A division of Chevron's medical staff that employs or contracts for the services of licensed counselors who can provide crisis counseling, assessment and referrals for retirees and dependents seeking treatment for mental health and substance abuse problems. If you want to speak with a counselor from Employee Assistance and WorkLife Services about a personal problem, or if you need a referral to a provider in the ValueOptions network, you can call 1-800-860-8205 or 1-925-842-3333 anytime of the day or night.

## Claims Administrator (Dental Plan)

See UCCI Companies, Inc. ("United Concordia")

## Claims Administrator (Medical PPO Plan)

UnitedHealthcare is the claims administrator for medical services. You can contact UnitedHealthcare at 1-800-654-0079. To get a list of UHC PPO network providers, log on to [www.myuhc.com](http://www.myuhc.com). To find an out-of-network provider affiliated with MultiPlan that has agreed to provide discounted rates, call 1-800-654-0079 or access the website at [www.myuhc.com](http://www.myuhc.com). Click on Physicians and Facilities and then select Find Shared Savings Physicians & Facilities. (In order to use the provider search tool for the Shared Savings feature, you must be a registered user and log in to the myuhc.com website.) You can reach Personal Health Support at 1-800-654-0079.

## Claims Administrator (Chevron Medicare Plus Plan, Chevron Medicare Standard Plan, Chevron Senior Care Plan)

If you participate in the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan or the Chevron Senior Care Plan, your claims administrator is UnitedHealthcare for medical services. You can contact UnitedHealthcare at 1-800-654-0079 or access its website at [www.myuhc.com](http://www.myuhc.com). To get a list of UHC PPO network providers, you can log on to the website at [www.myuhc.com](http://www.myuhc.com). **Note:** You must be a registered member to use the myuhc.com website.

## Claims Administrator (Medical PPO - Prescription Drug Program)

Express Scripts is the claims administrator of the Prescription Drug Program. Express Scripts has a network of retail pharmacies and a home delivery pharmacy program. They manage the program's pharmacy network and review, approve (or deny) and process claims. You can contact Express Scripts at 1-800-987-8368 or access its website at [www.Express-Scripts.com](http://www.Express-Scripts.com). To get a list of Express Scripts network pharmacies, you can log on to the website at [www.Express-Scripts.com](http://www.Express-Scripts.com). **Note:** You must be a registered member to use the Express-Scripts.com website.

## 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.

## 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 or retirees of such subsidiary that may participate in the Omnibus Health Care Plan.

## Contracted Fees

The amount a participating provider agrees to accept as payment in full for covered services. Contracted fees are usually lower than the provider's normal charge.

## Copayment

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

## Corporation

Refers to Chevron Corporation.



## **Covered Charges (Medical PPO Plan)**

The plans pay only for health services that are medically necessary and appropriate for the diagnosis and treatment of sickness or injury, and for certain preventive care services. Benefits paid for these services provided by out-of-network providers are based on allowable charges for the service or supply provided. You have to pay for services and supplies that aren't covered under the plan. And, if you go to an out-of-network provider, you must pay any charges in excess of allowable charges. If you go to a PPO network provider for care, plan benefits are based on the discounted rates ("contracted fees") the provider charges, instead of on allowable charges. Covered charges can be either the contracted fees you are charged by a network provider or the allowable charges for an out-of-network service or supply.

## **Covered Charges (Chevron Medicare Plus Plan, Chevron Medicare Standard Plan, Chevron Senior Care Plan)**

The amount of any benefit paid under these plans is determined based on the charges recognized by the plans. These recognized charges are called *covered charges*.

With the exception of prescription drugs and the Vision Program benefits, covered charges under these plans will be either the Medicare-approved amount or the allowable charge, depending on the situation.

Covered charges for the services and supplies covered by these plans and also covered by Medicare always will be based on the Medicare-approved amount. A service or supply covered under these plans must be used for the treatment of a nonoccupational sickness or injury provided under the care or direction of a doctor.

**When the provider accepts Medicare assignment** of benefits, covered charges for any benefits payable under the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, or the Chevron Senior Care Plan, if any, will be based on the actual Medicare-approved amount.

**When the provider does not accept Medicare assignment** of benefits, covered charges for benefits payable under the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, or the Chevron Senior Care Plan, if any, will be based on the maximum amount Medicare permits providers to charge for covered services, currently 115 percent of the Medicare-approved amount.

Covered charges for prescription drugs are determined by the Prescription Drug Program. Covered charges for all other services and supplies not covered by Medicare, like private-duty nursing care, will always be based on the allowable charge.

## **Covered Charges (Dental PPO Plan)**

Charges the plan pays for medically necessary services and supplies that are ordered by and while under the care and direction of a dentist or a doctor (although not all treatment or services prescribed by a dentist are considered covered charges) and that are covered by the plan.

Network covered charges for those services and supplies are limited to the negotiated fees between UCCI and the providers. See the definition for negotiated fees in this section.

Out-of-network covered charges for those services and supplies are limited to UCCI's allowance for dental treatment that's either provided by a dentist or doctor or provided under the direction of a dentist or doctor. See the definition for UCCI's Allowance in this section.

## **Custodial Care**

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

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

## **Day Treatment Program**

Care provided in a hospital, residential care or day treatment facility when the patient spends at least six hours a day in treatment at the hospital or facility but doesn't spend the night.

To qualify for Mental Health/Substance Abuse Plan benefits, the care must be part of a structured treatment program that satisfies *all* of the following requirements:

- It is supervised by an M.D. or a Ph.D. who qualifies as a clinician.
- It includes a variety of treatment methods, such as medical services and group and individual psychological, vocational and recreational therapies.
- It is licensed, certified or approved by the state in which it operates or is provided under the direction of a hospital or residential treatment program that's licensed, certified or approved by the state.

## **Dentist or Doctor (Dental PPO Plan)**

The plan can help pay for services performed by a doctor or dentist (D.M.D. or D.D.S.) who is licensed by the governmental authority having jurisdiction over licensing in the locality of the doctor's or dentist's practice. The plan also covers services of a dental hygienist, a person who is licensed by the state and working under a dentist's supervision.

## **Doctor (Medical PPO Plan, Chevron Medicare Plus Plan, Chevron Medicare Standard Plan, Chevron Senior Care Plan)**

The term "doctor" means a doctor or surgeon (M.D.), a psychiatrist (M.D.), an osteopath (D.O.), a podiatrist (D.P.M.), a dentist (D.M.D. or D.D.S.), a chiropractor (D.C.) and an ophthalmologist (O.D.).

For care to be covered under the plans, the doctor must be licensed by the proper authorities of the state in which he or she practices, and practice and treatment must be within the scope of the doctor's license.

## Durable Medical Equipment

Durable medical equipment must meet *all* of the following requirements:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose.
- Is generally not useful to a person in the absence of sickness or injury.
- Is appropriate for use in the home.

## Eligible Provider (Mental Health and Substance Abuse Plan)

The term “eligible provider” refers to a:

- **Hospital** — a legally constituted and operated institution having, on its premises, organized facilities for the care and treatment of sick persons. Care must be supervised by a staff of legally qualified doctors, with a registered nurse (R.N.) on duty at all times. The term “hospital” doesn’t include any institution used principally as a rest or nursing facility; any facility solely for use by the aged, the chronically ill or convalescents; or a facility providing primarily custodial, educational or rehabilitative care (other than a hospital that provides primarily rehabilitative care for substance abuse).
- **Residential care facility** — a hospital-based or free-standing facility that provides 24-hour care and structured treatment programs, is staffed by a multidisciplinary team of health care professionals, and is licensed, certified or approved by the state in which it operates.
- **Clinician** — a doctor or surgeon (M.D.), psychiatrist (M.D.), psychologist (Ph.D. or master’s level), social worker, therapist or counselor who is licensed or certified for independent practice by the proper authority of the state in which he or she practices and who is practicing within the scope of the license or certification. In states where state law doesn’t provide for licensing or certification, “social worker” means a professional who is certified by the American or National Board of Examiners in Clinical Social Work.

If you have a question about whether or not your provider is eligible, contact ValueOptions at 1-800-VIP-CHEV (1-800-847-2438).

## **Experimental or Investigational Service (Medical PPO Plan)**

A medical, surgical, diagnostic, psychiatric, mental health, substance abuse or other health care plan service, technology, supply, treatment, procedure, drug therapy or device that is determined by the claims administrator to be any of the following:

- Not approved by the U.S. Food and Drug Administration (“FDA”) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- Subject to review and approval by any institutional review board for the proposed use; or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The Medical PPO claims administrator, in its judgment, may deem an Experimental or Investigational Service covered under the Medical PPO for treating a life-threatening sickness or condition if the Medical PPO claims administrator determines that the Experimental Service:

- Is proved to be safe with promising efficacy; and
- Is provided in a clinically controlled research setting; and
- Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

For the purpose of this definition, the term “life-threatening” is used to describe sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.

## **Experimental or Investigational Service (Chevron Medicare Plus Plan, Chevron Senior Care Plan, Chevron Medicare Standard Plan)**

A medical, mental health/substance abuse or other health plan service, supply or drug that is any of the following:

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

## **Experimental and Investigative Services (Dental PPO Plan)**

With respect to the Dental PPO Plan, the use of any treatment, procedures, facility, equipment, drug or drug usage, device, or supply which is not acceptable standard dental treatment of the condition being treated, or any such items requiring federal or other governmental agency approval when such approval has not been granted at the time the services are rendered, as determined by the Dental Plan Claims Administrator in its sole discretion.

## **Gender Identity Disorder (Medical PPO Plan)**

A disorder characterized by the following diagnostic criteria:

- A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
- Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
- The disturbance is not concurrent with a physical intersex condition.
- The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

## **Generic Drug (Medical PPO - Prescription Drug Program)**

A chemical copy of a brand-name prescription drug. Generic medications contain the same active ingredients and must be equivalent in strength and dosage to their brand-name counterparts. They are subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength and purity as their brand-name counterparts. Generally, generic drugs cost less than brand-name drugs.

Some generics look different from the brand-name version of the drug because they contain different inactive ingredients. Inactive ingredients are, for example, additives that are used to keep a tablet from crumbling, to add bulk to a tablet, or to change a tablet's color or shape. Generic drugs typically cost 30 percent to 60 percent less than their brand-name counterparts because manufacturers of generic drugs don't have to pay for research and development or marketing and advertising.

## **Health and Welfare Eligibility Service (HWES)**

Your health and welfare eligibility service is used to determine your eligibility for retiree health care benefits. For more information about HWES, see the Company Contributions to Retiree Medical Coverage Supplement.

## **HIPAA**

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

## **Home Health Care Agency**

A home health care agency provides services such as part-time or intermittent skilled nursing care, teaching and rehabilitation services. It also may provide rehabilitation equipment, based on a treatment plan prescribed by the patient's doctor. The agency must be certified by Medicare and participate in the federal Medicare program in order for its charges to be covered under the plan.

## Hospice

Hospices offer an alternative to hospital care for treating terminally ill patients and counseling their families. They are licensed programs or facilities designed to care for terminally ill patients with life expectancies of less than six months. Hospice care can be provided on an inpatient basis or in the patient's home.

## Hospital

A hospital must meet one of the following requirements:

- A legally constituted and operated institution having, on its premises, organized facilities (including diagnostic and major surgical facilities) for the care and treatment of sick and injured people. Care must be supervised by a staff of legally qualified doctors, and there must be a registered nurse (R.N.) on duty at all times.
- A free-standing rehabilitative facility that meets all of the following criteria:
  - Has a provider agreement, as required by Medicare.
  - Serves an inpatient population, with at least 75 percent of patients needing intensive rehabilitative services for the treatment of a stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of the femur, brain injury, polyarthritis, neurological disorders and burns.
  - Has a preadmission screening procedure to determine whether the patient would benefit from an intensive inpatient hospital program.
  - Ensures that patients receive close medical supervision and furnishes rehabilitation nursing, physical therapy and occupational therapy by qualified personnel.
  - Has a director of rehabilitation who is a doctor.
  - Establishes a plan of treatment for every patient that is reviewed as needed by a doctor who consults with other qualified personnel.
  - Uses a coordinated team approach to rehabilitate each patient.

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

- Any institution used primarily as a rest or nursing facility.
- Any facility solely for use by the aged or the chronically ill or alcoholics.
- Any facility providing primarily educational or custodial care.

## **Incapacitated Child**

An incapacitated child is a dependent child who is:

- Incapable of self-sustaining employment by reason of mental retardation or a mental or physical disability (proof of which must be medically certified by a physician);
- Dependent on you, 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:

- 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 became an eligible employee; or
- Before turning age 26 if he or she had other health care coverage immediately before the dependent child was enrolled in the Chevron health care plan.

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

## **Inpatient Care**

Care that's provided while an individual is confined as a bed patient in a hospital.

## **Maintenance Medication (Medical PPO - Prescription Drug Program)**

Medication taken over an extended period of time (90 days or more) for the treatment of a chronic condition, such as diabetes, arthritis, ulcers, high blood pressure or heart conditions.

## **Managed Prior Authorization (Medical PPO - Prescription Drug Program)**

The Express Scripts program that requires certain drugs to be approved by Express Scripts before the drug is dispensed in order for the drug to qualify as a covered charge.

## **Medical Channel Management (Medical PPO - Prescription Drug Program)**

The Express Scripts program aimed at identifying opportunities for shifting drug utilization from the medical channel to the pharmacy channel with respect to specialty drugs.

## **Express Scripts Medicare™ (PDP) Evidence of Coverage (EOC) Document**

Describes prescription drug plan benefits for participants under the Chevron Medicare Plus Plan, the Chevron Medicare Standard Plan, and the Chevron Senior Care Plan. Members receive a copy of the EOC each year. You also can call Express Scripts at 1-800-935-6215 to request an additional copy.

### **Medically Necessary (Chevron Medicare Plus Plan, Chevron Medicare Standard Plan, Chevron Senior Care Plan, Medical PPO Plan)**

This term generally refers to health care services or supplies that are determined by the claims administrator, in its sole discretion, to be medically appropriate and that are all of the following:

- Necessary to meet the basic health needs of the plan member or covered dependent.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the health care service or supply.
- Consistent in type, frequency and duration with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the claims administrator as to the type, frequency or duration of treatment.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the comfort or convenience of the patient, the patient's family, the doctor or another provider.
- Demonstrated through prevailing peer-reviewed medical literature to be either of the following:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed.
  - Safe with promising efficacy for treating a life-threatening sickness or condition, provided in a clinically controlled research setting, and using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

For purposes of this definition, the term "life-threatening" is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment. The fact that a doctor has performed, prescribed, ordered, recommended or approved a procedure or treatment, or the fact that it may be the only treatment for a particular illness, injury or pregnancy doesn't mean that it's medically necessary and appropriate as defined here.

### **Medically Necessary (Dental PPO Plan)**

This term generally refers to services or supplies that are prescribed by a dentist or doctor and accepted by the health care community as being reasonable and necessary for treatment of the condition. Medically necessary services can include those that are appropriate and necessary to diagnose, treat and care for a dental condition.

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



## **Medically Necessary (Mental Health and Substance Abuse Plan)**

Medically necessary services are those that are:

- Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (ICD-9 or DSM-IV) that threatens life, causes pain or suffering or results from illness or infirmity.
- Expected to improve an individual's condition or level of functioning.
- Individualized, specific and consistent with symptoms and diagnosis and not in excess of patient's needs.
- Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications.
- Reflective of a level of service that is safe, where no equally effective, more conservative and less costly treatment is available.
- Not primarily intended for the convenience of the recipient, caretaker or provider.
- No more intensive or restrictive than necessary to balance safety, effectiveness and efficiency.
- Not a substitute for non-treatment services addressing environmental factors.

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

## **Multi-Source Drug (Medical PP - Prescription Drug Program)**

A medication that is available from multiple manufacturers and can include Brand-Name Drugs and Generic Drugs depending on patent status.

## **Negotiated Fee(s) (Dental PPO Plan)**

The amount(s) a participating network provider agrees to accept as payment in full for covered services. Negotiated fees are the fees agreed to by UCCI and the providers and are discounted to be usually lower than the provider's normal charge.

## **Network Pharmacy (Medical PPO - Prescription Drug Program)**

Express Scripts, the administrator of the Prescription Drug Program's retail pharmacy program for non-Medicare participants, has negotiated a discount agreement with more than 60,000 pharmacies across the U.S. These pharmacies make up a network that includes pharmacy chains, pharmacies at discount stores, pharmacies at local and national grocery chains and many independent pharmacies. For participating pharmacies near you, visit [www.Express-Scripts.com](http://www.Express-Scripts.com) or call Express Scripts Services at 1-800-987-8368.

## **Network Price (Medical PPO - Prescription Drug Program)**

A discounted price charged for a prescription drug when a network pharmacy is used.

## **Non-preferred Brand-Name Drugs (Medical PPO - Prescription Drug Program)**

Drugs that are covered by the Prescription Drug Program, which receive a lower level of reimbursement compared with preferred brand-name drugs. These drugs are not on Express Script's list of preferred brand-name drugs.

## **Nurse**

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

## **Nurse-Midwife**

A registered nurse who has passed the American College of Nurse-Midwives' national exam for certification.

## **Open Enrollment**

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

## **Out-of-Pocket Maximum (Medical PPO Plan, Prescription Drug Program, Mental Health and Substance Abuse Plan)**

After you pay your deductible, the plan pays a percentage of covered charges for the care you need and you pay any costs above the amount paid by the plan.

After your out-of-pocket costs reach the specified amount for the coverage tier, the plan pays 100 percent of all covered charges until the end of the calendar year.

## **Outpatient Care**

Care provided without an overnight stay in a hospital.

## **Outpatient Prescription Drugs (Medical PPO - Prescription Drug Program)**

Drugs that are dispensed by a retail or home delivery pharmacy (excluding drugs dispensed at hospitals, doctors' offices or skilled nursing facilities).

## **Outpatient Treatment**

Treatment or care provided without an overnight stay in a medical facility.

## **Preferred Brand-Name Drugs (Medical PPO - Prescription Drug Program)**

Drugs that are covered by the Prescription Drug Program and receive a higher level of reimbursement compared with nonpreferred drugs. The list of preferred brand-name drugs (sometimes called a formulary list) includes commonly prescribed medications that have been selected based on their clinical effectiveness and on opportunities for savings. Preferred brand-name drugs receive a higher level of reimbursement compared with nonpreferred brand-name drugs. For updated formulary information, visit [www.Express-Scripts.com](http://www.Express-Scripts.com) or call Express Scripts Member Services at 1-800-987-8368.

## **Primary Payer**

The plan that pays benefits first.

## Prosthetic Devices

Devices that replace a limb or body part. The device must be ordered or provided by, or under the direction of, a doctor. Examples of prosthetic devices include:

- Artificial limbs.
- Artificial eyes.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998.

## Provider

A hospital, medical or health care facility, doctor, dentist or other health professional licensed where required, performing within the scope of that license.

- A PPO (preferred provider organization), participating provider or network provider has agreed to charge discounted rates for services provided to plan members. To encourage you to use these providers, the plan often pays a higher benefit rate for network services. Also, you generally don't have to file a claim form when you go to a network provider. You can obtain a list of network providers in your area by contacting your claims administrator.
- A non-PPO, nonparticipating or out-of-network provider does not have an agreement with the claims administrator pertaining to the payment of covered services for a member.

## Qualified Domestic Relations Order

Generally, your rights and benefits under the plans cannot be assigned, sold, transferred or pledged by you or reached by your creditors or other party except under a qualified domestic relations order (QDRO), as explained here.

A domestic relations order is any court order made pursuant to a state domestic relations law that relates to divorce, legal separation, custody or support proceedings. The order must be honored by certain of the Chevron benefit plans if the order meets certain requirements to qualify as a QDRO.

The QDRO recognizes the right of someone other than you to receive your plan benefits. The order could include an award to a former spouse of a portion of plan benefits you or your beneficiary is eligible to receive. This means that your benefits would be reduced and the benefits payable to your surviving spouse or beneficiary would also be less.

If you want more information about qualified domestic relations orders, or to obtain (at no charge) a description of the procedures for QDRO determinations, you can write to:

The QDRO Processing Group  
P.O. Box 436  
Little Falls, NJ 07424

Or via overnight mail to:

The QDRO Processing Group  
Chevron Corporation  
930 North River View Drive, Suite 800  
Totowa, NJ 07512

## **Residential Treatment Program**

A program of treatment given in a facility that provides 24-hour residential care to patients who don't require acute-care services or 24-hour nursing care. The program provides structured mental health or substance abuse treatment that includes medical supervision by a doctor and is staffed by a multidisciplinary team, which may include doctors, psychologists, social workers, registered nurses (R.N.) and other health care professionals. The program must be licensed, certified or approved by the state in which the program operates.

## **Secondary Payer**

The plan that pays benefits second.

## **Single-Source Brand-Name Drugs (Medical PPO - Prescription Drug Program)**

A Brand-Name Drug that doesn't have a generic equivalent and is only available from one manufacturer or source, typically the original company.

## **Skilled Nursing Facility**

An institution that charges a fee and meets *all* of the following requirements:

- It furnishes room and board and nursing services for medical care.
- It has one or more licensed nurses on duty at all times, working under the constant supervision of a registered nurse (R.N.) or licensed doctor.
- It has available, at all times, the services of a licensed doctor.
- It complies with all legal requirements applicable to the operation of such an institution.
- It maintains medical records on all its patients at all times.
- It is approved under Medicare.

The term "skilled nursing facility" doesn't include any of the following:

- An institution used primarily as a rest facility.
- Facilities for the aged or for drug addicts or alcoholics.
- Facilities provided primarily for custodial or educational care.

## **Specialty Drug (Medical PPO - Prescription Drug Program)**

A prescription drug that Express Scripts has designated as a Specialty Drug.

In general, Specialty Drugs are high-cost drugs that may be used to treat complex and/or rare medical conditions. Specialty Drugs are generally biotechnological in nature and may have special shipping, storage or handling requirements. Specialty Drugs often require injection or other non-oral methods of administration. Some of the disease categories for which certain prescription drugs are currently designated as Specialty Drugs by Express Script's include cancer, cystic fibrosis, Gaucher disease, growth hormone deficiency, hemophilia, immune deficiency, Hepatitis C, infertility, multiple sclerosis, rheumatoid arthritis, and RSV prophylaxis. Express Scripts may add or delete drugs from the Specialty category as new treatments become available. For information on whether a particular drug is a Specialty Drug, or whether it is subject to the home delivery requirement for maintenance Specialty Drug refills, contact Express Scripts at 1-800-987-8368.

## **Specialty Pharmacy (Medical PPO - Prescription Drug Program)**

Express Scripts Specialty Pharmacy, Accredo. A Specialty Drug must be ordered through the Specialty Pharmacy in order to be a covered charge.

## **Spouse**

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

## **UCCI Companies, Inc. ("United Concordia")**

The claims administrator for the Chevron Dental Plan. They manage the plan's preferred provider organization and review, approve (or deny) and process claims filed by you or your provider. They can be reached by telephone at 1-877-424-3876 between 8 a.m. and 5 p.m. Pacific time, Monday through Friday. UCCI also sponsors the Concordia Plus dental HMO option available to Chevron retirees who live in the plan's service area.

## **UCCI's Allowance (Dental PPO Plan)**

For out-of-network providers, UCCI's allowance may vary from one U.S. geographic area to another, is based on a range of rates and fees that most dentists and specialists charge for the same service in that area, and must be no more than the out-of-network provider normally charges for the service or supply. When reviewing charges to determine if they're covered under the plan's out-of-network coverage, United Concordia doesn't attempt to set the amount that nonparticipating dentists and other providers charge for needed services, nor do they restrict your right to go to any dentist you choose. However, United Concordia determines UCCI's allowance, and you're responsible for paying the difference between your nonparticipating dentist's charge and the allowance established by United Concordia. For services received outside of the U.S. the allowance is the billed amount.

## UnitedHealthcare (UHC)

UnitedHealthcare is the claims administrator for the Medical PPO in all states. UHC reviews, approves (or denies) and processes all claims other than claims for outpatient prescription drugs and vision care. UHC also manages the PPO network of providers. In addition, their staff informs plan members which charges are covered and which aren't under the plan. If you have a question about a claim or if you need to speak with a customer service representative, call UnitedHealthcare at 1-800-654-0079. For a list of UHC PPO network providers, you can log on to the website at [www.myuhc.com](http://www.myuhc.com). UHC also offers a team of registered nurses as part of your benefit – the Nurse Advisor Team -- dedicated solely to Chevron. You can call a Nurse Advisor with questions or concerns for health matters big and small. A Nurse Advisor can help you with condition management (for example diabetes or asthma), understanding an illness, an upcoming hospitalization, major surgery or treatment options. They can also help you understand and follow your doctor's treatment plan and self-care suggestions, provide you with educational materials and individualized support, find doctors or other health care professionals in the network as well as connect you with communication resources. You can contact a nurse 24 hours a day, 7 days a week at 1-800-654-0079.

UHC's Personal Health Support, a pre-service review team administers the plan's Health Care Review procedures. The Personal Health Support staff reviews proposed hospitalization and other specified procedures to confirm they're medically necessary for the condition being treated. Approval is required before full plan benefits can be paid for some kinds of care. You can call Personal Health Support at 1-800-654-0079 between 7 a.m. and 5 p.m. Pacific time, Monday through Friday.

UHC is also the claims administrator for the Medicare Plus Plan, Senior Care Plan and the Medicare Standard Plan

## ValueOptions

The Mental Health/Substance Abuse Plan's (MHSA) claims administrator, ValueOptions has a broad network of professional health care providers in most locations where Chevron retirees live. Benefits are available to non-Medicare retirees and their non-Medicare dependents who are enrolled in the Medical PPO. ValueOptions reviews the treatment processes that these providers use and approves (or denies) proposed treatment plans. In addition, ValueOptions provides administrative services, such as paying providers and processing claims for benefits. More information about ValueOptions is available online at [www.valueoptions.com](http://www.valueoptions.com).

You can call ValueOptions for a referral to a network provider at any time of day or night — or for customer service between 8 a.m. and 5 p.m. Pacific time, Monday through Friday. The toll-free telephone number is 1-800-VIP-CHEV (1-800-847-2438). If you're calling from outside the U.S., use the AT&T Direct Service code in the country you're calling from, and then dial 1-800-847-2438. ValueOptions claims should be mailed to P.O. Box 1290, Latham, NY 12110.

## ValueOptions Network

The Mental Health and Substance Abuse Plan's network includes more than 33,000 psychotherapists, social workers and psychologists who are experts in treating mental health and substance abuse problems. The network also includes 1,600 hospitals and residential care facilities nationwide.

Counselors from ValueOptions and Chevron's Employee Assistance and WorkLife Services provide referrals to network providers in your area when you or a dependent needs treatment for a mental health or substance abuse problem. You can call ValueOptions at 1-800-VIP-CHEV (1-800-847-2438). (From outside the U.S., use the AT&T Direct Service code in the country you're calling from, and then dial 1-800-847-2438.)

## **VSP (Vision Service Plan) Vision Care**

VSP is the insurer for the vision benefits you receive through the Medical PPO, Chevron Medicare Plus Plan, Chevron Medicare Standard Plan, and Chevron Senior Care Plan. VSP manages the plan's preferred provider organization and processes claims filed by you or your provider. VSP can be reached by telephone at 1-800-877-7195 Monday through Friday from 5 a.m. to 8 p.m. Pacific time, Saturday from 7 a.m. to 8 p.m. Pacific time and on Sunday 7 a.m. to 7 p.m. Pacific time. Or you can access the VSP's website at [www.vsp.com/go/chevron](http://www.vsp.com/go/chevron).