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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** 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 Global Choice Plan (Expatriates in the U.S.) and Chevron Dental Plan sections of the Health Benefits for Expatriates in the U.S. Summary Plan Description** (both the SPD posted online and the SPD available in print.)

global choice plan

effective january 1, 2017

There are few changes to your Global Choice Plan (Expatriates in the U.S.) for 2017. The changes effective January 1, 2017 are included in this document.

The Global Choice Plan (Expatriates in the U.S.) is the only medical plan option available to you while you're on a expatriate assignment in the U.S. The Global Choice Plan offers comprehensive coverage for the medical services you'd expect, including office visits, emergency services, hospital care, lab services, outpatient care, pregnancy and newborn care, and rehabilitative services.

Medical Services
All covered medical services are insured by Cigna — whether inside or outside the United States.

Prescription Drugs
Express Scripts administers your prescription drugs for prescriptions obtained in the United States or by mail-order within the United States. *Cigna* administers your prescription drugs for covered prescriptions obtained outside the United States.

Basic Vision
If you're enrolled in the Global Choice Plan, you're automatically covered by the Vision Program for basic vision coverage with VSP.

This communication 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 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.

what's changing

how your U.S. out-of-network claims are paid

The following information only refers to claims incurred in the U.S.
This does not apply to claims incurred outside the U.S.

The **Global Choice Plan (Expatriates in the U.S.)** provides access to a network of providers in the United States. To be a part of Cigna's network, doctors and facilities must meet certain credential requirements and agree to accept a contracted rate for covered services. Providers that meet the requirements are considered **network providers**. If a doctor or facility has no contract with Cigna, they are considered **out-of-network** and can charge you full price. Cigna can't control what they charge for their services, and the price they charge is usually higher than the network contracted rate.

One of the benefits of the Global Choice Plan is the flexibility to use any U.S. doctor you choose – in or out of the network. Your share of the costs – the coinsurance – will often be lower if you use a network provider. This isn't changing. When you use a network provider in the U.S., the plan will pay **100 percent** of the cost for covered medical services. If you do not use a network provider in the U.S., that's your choice, but the plan will pay only **70 percent** of the cost for most covered medical services for an out-of-network provider, and you will pay the remainder. Chevron will not reimburse you for this expense. Starting January 1, 2017, there will be an additional change in how your out-of-network claims for covered medical services will be paid, which will also affect your costs when you choose to use an out-of-network provider.

The **maximum reimbursable charge (MRC)** is the maximum amount the Global Choice Plan will pay for covered out-of-network services. You will be responsible for paying any amount **above** the plan's MRC for the service. Generally, your provider will bill you for this amount and you'll pay the provider directly. Providers often refer to this as *balance billing*. These payments do not apply to your out-of-pocket maximum. And these payments are *in addition to* your coinsurance obligation for the service.

Note: U.S. emergency services are covered at the network cost sharing level even when you receive care from an out-of-network doctor or facility.

Here's a simple example of how this works.[1]
Assume you receive a covered service from an out-of-network provider in the United States.

	Network provider	Out-of-network provider
Covered charge (Billed rate)	$280	$280
Covered charge (Contracted rate)	**$170**	No contracted rate available.
Maximum reimbursable charge (MRC)	Not applicable	**$218**
Your coinsurance obligation[2]	**$0** No coinsurance for network provider	**$65.40** (30% x $218)
Amount above MRC	**$0** Not applicable.	**$62** Provider may balance bill you directly for this amount. It's your responsibility to pay this bill.
Your total out-of-pocket cost	**$0**	**$127.40** (Your $65.40 coinsurance + $62 balance billing amount)

1. This is an example used for illustrative purposes only. Actual covered charges and out-of-pocket costs will vary.
2. When you use a network provider in the U.S., the plan will pay 100 percent of the cost for covered medical services. If you do not use a network provider in the U.S., that's your choice, but the plan will pay only 70 percent of the cost for most covered medical services for an out-of-network provider, and you will pay the remainder.

prescription drugs obtained inside the U.S.

Cigna is the insurer for prescription drugs obtained *outside* the United States. There are no changes to your Cigna prescription drug coverage for 2017.

Express Scripts is the insurer for the Prescription Drug Program which covers prescription drugs obtained **inside** the United States and through mail order within the United States. The Prescription Drug Program currently has prior authorization, Drug Quantity Management and Preferred Step Therapy programs in place. There are administrative changes to these programs, *only*. You don't need to do anything.

You'll be notified by Express Scripts if your medication is subject to any of these programs during 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 and Drug Quantity Management programs, contact Express Scripts Member Services at 1-800-987-8368. See the information below for a quick review about what prior authorization, Drug Quantity Management and Preferred Step Therapy means.

- 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**.
- **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.
- 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.