chevron open enrollment

and COBRA benefit changes effective january 1, 2023

(unless otherwise indicated)

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. Oral statements about plan benefits are not binding on Chevron or the applicable plan. 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.

open enrollment is here

It's time to make open enrollment elections for your 2023 Chevron COBRA coverage. **Open enrollment is November 1 through November 15, 2022.** Any elections you make for your COBRA coverage during open enrollment become effective January 1, 2023. This newsletter provides information about changes to your COBRA benefits and how to enroll.

Be sure to learn about the changes coming to your 2023 benefits prior to making open enrollment elections. Information about plan changes start on Page 5 of this newsletter. In addition, watch for these important communications to arrive under separate cover from **BenefitConnect | COBRA**:

- A personalized, **2023 COBRA Enrollment Notice** in early November.
  This package will include:
  - Information about accessing the BenefitConnect | COBRA enrollment website.
  - Detailed instructions for making COBRA open enrollment elections.
  - A personalized 2023 COBRA Premium Rate sheet that provides premium costs, plan choices and the coverage levels available to you.

- A **COBRA Payment Coupon** packet in early December.
  This package will include:
  - A monthly coupon book you'll use to mail your 2023 premium payments.

how to enroll
november 1 through november 15, 2022

by phone

1-877-292-6272
1-858-314-5108 outside the U.S.
BenefitConnect | COBRA Service Center

Representatives available
Monday through Friday
6 a.m. to 4 p.m. Pacific time
8 a.m. to 6 p.m. Central time

Customer Service Representatives can take your open enrollment elections by phone until 4 p.m., Pacific time (6 p.m., Central time) on **November 15, 2022**.

online 24/7

hr2.chevron.com/OpenEnrollment
BenefitConnect | COBRA website
Access benefit information and the BenefitConnect | COBRA enrollment website. The website will be available for you to make open enrollment elections until **midnight Pacific time** on **November 15, 2022**.

You can log in to the enrollment website from any computer or mobile device with an Internet connection.

do i need to do anything?

Open enrollment is your annual opportunity to review your benefit options for the coming year. During open enrollment, you can decide to keep the coverage you currently have or make changes as permitted by plan rules.

If you miss the open enrollment deadline, you generally can't make any changes until the next open enrollment period in the fall of 2023 for 2024 benefits. However, you can make changes to certain benefits outside of the open enrollment period within the 31-day deadline after a qualifying life event, such as a marriage or birth. Any changes you make to your benefits coverage during open enrollment, **November 1** through **November 15, 2022**, become effective January 1, 2023.

you must act november 1 through november 15, 2022 if you need to...

start, stop or change coverage for these plans

Changes to the plans listed below are limited to once per year, during open enrollment, unless you have a qualifying life event during the year. If you're already enrolled in the plans below and don't want to make any changes, coverage automatically continues at the 2023 premium rates.

- Medical coverage
- Dental coverage
- Vision Plus Program
- Mental Health and Substance Abuse Plan
- Healthy You Program (previously called Healthy Heart Program)
- Health Decision Support

add, drop or update your dependent coverage

If you need to add or drop a dependent from medical, dental or other health coverage for 2023, you must make an election during open enrollment.

important reminder about retiree health benefits enrollment

If you are currently eligible for Chevron retiree health benefits, remember that you must enroll yourself and any eligible dependents in this coverage upon reaching certain enrollment milestones. **Loss of Chevron COBRA** coverage (including subsidized COBRA) is an enrollment milestone for retiree health benefits. If you miss this enrollment milestone, you and your eligible dependents must generally wait until the next applicable enrollment milestone, if any, to return to Chevron retiree health benefits in the future.

For information about your eligibility or to learn more about this and other enrollment milestones, call the HR Service Center at 1-888-825-5247 (1-832-854-5800 outside the U.S.) or review the enrollment milestones on **hr2.chevron.com/retiree**.

2023 chevron COBRA benefit changes

Update to the summary plan descriptions (SPD)
All changes described in this SMM are effective January 1, 2023 unless otherwise indicated.

The enclosed information 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. You can access the summary plan descriptions for your benefits at **hr2.chevron.com** or by calling the HR Service Center at **1-888-825-5247 (1-832-854-5800 outside the U.S**.)

This SMM describes changes to the following Chevron benefit plans:

06 - 23
Medical PPO Plan, High Deductible Health Plan, High Deductible Health Plan Basic

24 Prescription Drug Program

31 Mental Health and Substance Use Disorder Plan (MHSUD)

37 Dental PPO

39 Annual health benefit notices

your plan documents

These documents are posted online at **hr2.chevron.com** or you can request that a copy be mailed to you by calling the HR Service Center at 1-888-825-5247 (1-832-854-5800 outside the U.S.)

Summary of Benefits and Coverage (SBCs) provide summary information about your health plans, such as benefits, copayments, coinsurance, deductibles, 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, covered services, non-covered services and participation rules.

medical PPO plan
high deductible health plan (HDHP)
high deductible health plan basic (HDHP basic)

Contact **Anthem** directly at **1-844-627-1632** to discuss the benefits described here or for claims, coverage under your plan, or to find a network provider. For medical-related questions and concerns, please contact your provider directly before visiting the office. **As always call 911 or go to the emergency room if you think you need care right away.**
by calling the HR Service Center at **1-888-825-5247**.

family planning and related services
(previously referred to as *family planning and infertility services*)

snapshot of what's changing

Effective **January 1, 2023**, Medical PPO, HDHP and HDHP Basic participants have access to a new, free family building support program with **WIN Fertility (WIN)**. You are strongly encouraged to contact WIN as the first step on your fertility journey; WIN can help you better understand your options so you can maximize your benefit and choose a course of action that works for you.

The plans' **Family Planning and Related Services** coverage rules have also been updated to add coverage for storage costs for sperm and/or egg preservation and cryopreservation of fertilized embryos in connection with covered fertility treatment. Other clarifications have been added to more clearly reflect how existing coverage is administered, such as coverage for participants facing chemotherapy or radiation therapy under the medical plan. Lastly, plan participants have new access to elective, non-medically necessary fertility preservation egg and/or sperm freezing under the separate Chevron policy, **Surrogacy and Elective Fertility Preservation Reimbursement Program**.

There is no change to the coinsurance or deductible schedule, lifetime maximum amounts, or other general coverage rules and requirements. The complete rules – including existing and updated rules – effective January 1, 2023 are included below.

(continued next page)

Family Planning and Infertility Services	
Network (Medical PPO Plan)	80% of contracted rates after deductible.
Out-of-Network (Medical PPO Plan)	60% of the maximum allowed amount after deductible.
Network (HDHP)	80% of contracted rates after deductible.
Out-of-Network (HDHP)	60% of the maximum allowed amount after deductible.
Network (HDHP Basic)	70% of contracted rates after deductible.
Out-of-Network (HDHP Basic)	50% of the maximum allowed amount after deductible.

Family Planning and Related Services

WIN Fertility (WIN) Family Building Support Program

Starting January 1, 2023, Medical PPO, HDHP and HDHP Basic participants have access to a free family building support program with **WIN Fertility (WIN)**. WIN's nurse case managers provide personalized guidance and support through every step of the family planning and fertility process, including education and guidance about your plan's treatment and medication coverage, fertility preservation (egg/sperm freezing), adoption and surrogacy. **You are strongly encouraged to contact WIN as the first step on your fertility journey; WIN can help you better understand your options so you can maximize your benefit and choose a course of action that works for you**.

- 1-833-506-3473 (Starting January 1, 2023)
- managed.winfertility.com/chevron

What the Plan Covers

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

- 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.
- Selective reduction in multiple births.
- Abortions, either medically necessary or elective.
- In connection with the treatment of cancer, cryopreservation of mature oocytes in post pubertial individuals facing anticipated infertility resulting from chemotherapy or radiation therapy.

Family Planning and Related Services (continued)

What the Plan Covers (continued)

- "Morning-after" pills (such as Preven and Mifeprex)
- Physician-prescribed contraceptives that require insertion by a physician or significant physician follow-up, such as injectable contraceptives, implants (such as Depo-Provera or Levonorgestrel), IUDs, diaphragms, other removable devices and related office visits.

The following services to facilitate a pregnancy are covered by the plan and are subject to an aggregate **$60,000** per person lifetime maximum benefit:

- In vitro fertilization.
- Embryo transfer.
- Gamete intrafallopian transfer (GIFT).
- Zygote intrafallopian transfer (ZIFT).
- Tubal ovum transfer.
- Storage costs for sperm and/or egg preservation and cryopreservation of fertilized embryos in connection with covered fertility treatment for a covered participant's sperm or egg, and for a covered participant's own use. Preservation storage costs are covered for up to 12 consecutive months measured from the first date of storage.

This lifetime maximum benefit aggregates the covered services accumulated while an eligible participant in the Chevron Medical PPO Plan, the Chevron High Deductible Health Plan (HDHP), the High Deductible Health Plan Basic (HDHP Basic), or any combination thereof.

What the Plan Does Not Cover

Charges not covered include:

- Charges related to surrogate parents and charges incurred by a sperm or egg donor.
- Over-the-counter supplies.
- Supplies or medicines provided outside a physician's office.
- Oral contraceptives are covered under the Chevron Prescription Drug Program.

Elective Fertility Preservation

The Medical PPO, HDHP, HDHP Basic only provide coverage for medically necessary fertility treatment. For elective, **non-medically necessary** fertility preservation egg and/or sperm freezing, active employee plan participants also have access to a special feature under the **Surrogacy and Elective Fertility Preservation Reimbursement Program**. This program and the feature available to plan participants is *separate* from your medical plan and is *not* part of your plan's coverage for Family Planning and Related Services, as described above. You can review the program by going to the **Work Life Balance** section on **hr2.chevron.com**.

anthem engage to be replaced with anthem sydney health app

Effective **January 1, 2023** Anthem will discontinue the Anthem Engage app. It will be replaced with the expanded and enhanced **Anthem Sydney℠ Health mobile app**. With the enhanced app, you'll receive targeted health communications and resource recommendations from Anthem that are tailored specifically to you including appointment and testing reminders, provider recommendations, alternative care options, how to reduce your health care costs, condition support education, and other health program recommendations.

You can also use the Sydney Health mobile app to access the **virtual primary care service for online visits with an Anthem network provider**, secure in-app medical text chats for on-demand 24/7 urgent care, scheduled follow-up visits for wellness, prevention, and chronic condition care, and more. For further information and details about this covered service, see **Online Visits – Virtual Primary Care** in the *What the Plan Pays* section of your plan's summary plan description.

If you're already using the Sydney Health mobile app, changes are automatic with the next available app update after the transition. If you're currently using the Anthem Engage app, you will be prompted to download and upgrade to the Sydney Health app when the transition is complete.

new service option for online visits: virtual primary care

Where state laws allow, your Medical PPO Plan, HDHP and HDHP Basic plans currently provide two ways to access online (or virtual) health visits, through either the **LiveHealth Online** provider group or **directly through your personal physician**.

Effective **January 1, 2023**, a new *third* access option, **virtual primary care**, will be available through the expanded and enhanced **Anthem Sydney℠ Health** mobile app. Virtual primary care provides convenient and timely access to urgent, routine or preventive, and chronic condition care from healthcare professionals who focus on primary care – such as internal and family medicine – and are licensed to provide care where you live.

If you're already using the Sydney Health mobile app, changes are automatic with the next available app update after the transition. If you're currently using the Anthem Engage app, you will be prompted to download and upgrade to the Sydney Health app when the transition is complete.

Online visits for **virtual primary care** using the **Sydney Health mobile app** will follow this schedule of benefits:

- **Out-of-Network** Out-of-network benefits are not applicable. You must access virtual primary care through the providers available from the Sydney Health mobile app.
- **Network** Covered charges will include online visits from a virtual primary care provider available from the Sydney Health mobile app.
  - **Medical PPO:** 100% of contracted rates after a $25 copayment, per visit, no deductible.
  - **HDHP:** 80% of contracted rates after deductible.
  - **HDHP Basic:** 70% of contracted rates after deductible.

As with other online visit service options, non-covered services for virtual primary care include, but are not limited to, the following:

- Reporting normal lab or other test results.
- Office visit appointment requests or changes.
- Billing, insurance coverage, or payment questions.
- Requests for referrals to other Physicians or healthcare practitioners.
- Benefit precertification.
- Consultations between Physicians.
- Consultations provided by electronic mail or facsimile machines.

You will be financially responsible for all costs associated with non-covered services.

coordination of benefit rules

Effective **January 1, 2023**, Medical PPO, HDHP, and HDHP Basic coordination of benefits rules have been updated. When participants are receiving benefits from the Chevron Long-Term Disability Plan *and* are Medicare eligible due to disability, your plan will assume Medicare is the primary payor of any benefits for you and any other enrolled, Medicare-eligible dependents. This means your medical plan will pay secondary to Medicare, so if you are not enrolled in Medicare Part A and Part B, you will be responsible for a large part of claim costs.

expanded gender identity disorder coverage

snapshot of what's changing

In support of Chevron's diversity and inclusion journey, effective **January 1, 2023**, the plans will expand current **Gender Identity Disorder** coverage to *include* coverage for certain medically necessary and clinically appropriate gender affirming treatments, as described below. Covered treatments will comply with Anthem's clinical guidelines which follow current World Professionals Association for Transgender Health (WPATH) standards of care. There is no change to the coinsurance or deductible schedule, notification and clinical review requirements, and other general coverage requirements (also included here below for your reference). The complete rules – including existing and updated rules – effective January 1, 2023 are included below.

Gender Identity Disorder **Hospital Care* (inpatient and outpatient)**	
Network (Medical PPO Plan)	80% of contracted rates after deductible.
Out-of-Network (Medical PPO Plan)	60% of the maximum allowable amount after deductible.
Network (HDHP)	80% of contracted rates after deductible.
Out-of-Network (HDHP)	60% of the maximum allowable amount after deductible.
Network (HDHP Basic)	70% of contracted rates after deductible.
Out-of-Network (HDHP Basic)	50% of the maximum allowable amount after deductible.

Gender Identity Disorder **Office Visits***	
Network (Medical PPO Plan)	100% of contracted rates after a $40 copayment per visit, no deductible.
Out-of-Network (Medical PPO Plan)	60% of the maximum allowable amount after deductible.
Network (HDHP)	80% of contracted rates after deductible.
Out-of-Network (HDHP)	60% of the maximum allowable amount after deductible.
Network (HDHP Basic)	70% of contracted rates after deductible.
Out-of-Network (HDHP Basic)	50% of the maximum allowable amount after deductible.

** Review the **Hospital Care** and **Office Visit** tables in your plan's summary plan description for additional coverage information.*

Gender Identity Disorder
Continued

Before beginning treatment, you or your physician must contact Anthem to obtain precertification for any gender affirming/confirming surgical procedures. If you don't obtain precertification, no benefit will be paid for the surgical treatment or procedures.

The plan pays benefits for **inpatient and outpatient** treatment of Gender Identity Disorder/Dysphoria as follows:

- Charges for a clinically appropriate treatment plan of services that treats Gender Identity Disorder and that complies with the Anthem's clinical guidelines which follow the current WPATH (World Professionals Association for Transgender Health) standards of care, which may include, but is not limited to, hormonal balancing and medically necessary gender affirming/confirming surgical procedures, for example surgical facial hair removal, certain facial plastic reconstruction, genital surgery and chest reconstruction or augmentation.
    - The treatment plan must conform with identifiable external sources and/or evidence-based professional society guidance, as well as Anthem's clinical guidelines; and
    - For irreversible surgical interventions, the patient must be age 18 years or older; and
    - Prior to surgery, the patient must complete 12 months of successful continuous full time real life experience in the desired gender.
- Continuous hormone replacement - hormones of the desired gender injected by a medical provider. *Note:* Coverage may be available for oral and self-injected hormones may be covered under the Chevron Corporation Prescription Drug Program.
- Laboratory testing to monitor the safety of continuous hormone therapy.
- The surgery must be performed by a qualified physician at a facility with a history of treating individuals with gender identity disorder, as determined by Anthem.

Anthem has specific guidelines regarding benefits for treatment of gender identity disorder. Contact Anthem at the telephone number on your ID card for information about these guidelines.

Important: Certain patients will be required to complete continuous hormone therapy prior to surgery. In consultation with your physician, this will be determined by Anthem on a case-by-case basis through the precertification process.

The following services are not covered under the plan:

- Cryopreservation of fertilized embryos
- Drugs for hair loss or growth
- Drugs for sexual performance or cosmetic purposes (except for hormone therapy described above)
- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics
- Sperm preservation in advance of hormone treatment or gender surgery
- Treatment of the negative effects from hormone therapy that are not otherwise covered charges
- Treatment received outside of the United States
- Meals or similar expenses

medical PPO plan

expanded travel reimbursement benefit for covered medical services

overview

The Chevron Medical PPO Plan *currently* covers the cost of transportation and lodging only for certain emergencies and organ and tissue transplants. **Effective August 1, 2022, the Chevron Medical PPO Plan now also includes an expanded travel expense reimbursement benefit for all covered medical services if you cannot access the care you need where you live.** The benefit applies to a covered service received on or after August 1, 2022, and for travel to obtain that service on or after August 1, 2022.

how it works

This plan provision reimburses you for charges incurred for reasonable, qualifying travel expenses that are essential to receive any covered medical service under the Chevron Medical PPO Plan. To be eligible for reimbursement, *all* of the following requirements must be satisfied:

- **The covered service is not reasonably available to you from a network provider or facility within 100 miles of your home residence.**
  Reasonably available might include – but is not limited to – when there are no network providers or facilities who offer the service in your area, or you cannot get an appointment within a reasonable time based on your health situation.

- **The health care must be a covered medical service under the Chevron Medical PPO Plan.**
  - If the related medical service is not covered or benefits are denied, travel expenses will not be covered.
  - Note that this benefit only provides reimbursement for qualifying travel expenses; the cost of the covered service continues to be covered as per the plan's normal schedule of medical benefits and is separate from this travel benefit plan provision.
  - Reimbursement for eligible travel expenses is only available under the Chevron Medical PPO Plan. This plan provision *does not* apply to covered prescription drugs under the Chevron Prescription Drug Program or basic vision services under the Chevron Vision Program.
  - Travel expense reimbursement for organ and tissue transplant services are ineligible for reimbursement under this plan provision because they are already covered under the existing Organ and Tissue Transplant provision.
  - Travel expense reimbursements for online visits are also ineligible for reimbursement under this plan provision because this service can be accessed without the requirement to travel.

- **The expense must be a covered, qualifying travel expense.**
  In general, qualifying travel expenses for non-emergency transportation and/or lodging must be essential to obtain a covered medical service and are incurred by an enrolled participant (the patient) and caregiver, if any. See the *Qualifying Travel Expenses* section below for further details.

- **The qualifying expenses are incurred by the plan participant receiving the covered service - the patient - and eligible caregiver(s), if any.**

  To receive reimbursement for qualifying travel expenses, an eligible *caregiver* must meet **both** of the following requirements:

  - The caregiver is a person who can give injections, medications, or other treatment required by the patient who is unable to travel alone to receive the covered service.
  - The caregiver(s) must travel with the patient on the same day(s) to and from the site where the service is provided.

  If the patient is a dependent child enrolled in the Chevron Medical PPO, the qualifying travel expenses of up to **two** caregivers will be covered – a parent who must accompany the child and another caregiver. For adult patients, qualifying travel expenses for **one** caregiver will be covered.

- **Reimbursement is subject to IRS and plan reimbursement limits.**

  You are limited in the amount of reimbursement you can receive for qualifying travel expenses. Amounts in excess of any applicable limits will not be reimbursed. See the *Reimbursement Limits* section below for further details.

- **Reimbursement is *not* subject to the annual deductible.**

  While benefits for the covered medical service will continue to follow the Medical PPO Plan's normal deductible, coinsurance and copayment schedule, there is no separate deductible, coinsurance or copayment requirement for reimbursement of qualifying travel expenses.

- **The covered service must be received in the United States*, from either a network or out-of-network provider or facility.**

  While you are strongly encouraged to use a network provider or facility whenever possible, there is no network requirement to receive reimbursement under this plan provision.

  ** Includes a territory or possession under the jurisdiction of the United States.*

- **Properly completed travel claim(s) for reimbursement, including documentation, are submitted by the plan's claim filing deadline.**

  Submit your travel benefit claim as soon as possible after your related medical claim is approved. You must file a claim for reimbursement of travel expenses no later than six months (by June 30) following the calendar year in which the covered service was provided. If you don't file a proper claim within this time frame, travel expenses for the related covered service will be denied. Refer to the Medical PPO Plan summary plan description for more information about claim filing limitations and exclusions. See the *How to Use the Travel Benefit* section later in this document for further instructions about the travel claim process.

qualifying travel expenses

For purposes of this plan provision, qualifying travel expenses are generally non-emergency **Lodging** and **Transportation** expenses for *medical care* for which you could have claimed a tax deduction on an itemized federal income tax return. Guidance for what constitutes such an expense may be found in **IRS Publication 502 – Medical and Dental Expenses**. In general, qualifying transportation and/or lodging expenses must be essential to obtain a covered medical service and are incurred by an enrolled participant (the patient) and caregiver, if any.

General examples of **qualifying travel expenses** include but are not limited to:

- Mileage in your personal car to/from your home to the covered service provider or facility
- Rental cars
- Train or airline travel tickets
- Bus, shuttle, taxi and ride share services
- Lodging not provided by a hospital or other institution for the patient and caregiver, subject to IRS per diem limits
- Gas
- Tolls
- Long-term airport parking or other parking fees

Qualifying travel expenses do not include meals, personal use items (laundry, telephone calls, vehicle maintenance, etc.) or other travel expenses that relate to travel that is merely beneficial to general health and unrelated to a covered service, such as a vacation or personal trip. They also don't include amounts you pay for the care of children, even if the expenses enable you, your spouse or domestic partner, or your dependent to receive a covered medical service.

Review IRS Publication 502 available online at www.irs.gov for complete details about what are and are not qualifying expenses.

reimbursement limits

Under this provision, you are limited in the amount of reimbursement you can receive for qualifying transportation and lodging expenses. Amounts in excess of any applicable limits will not be reimbursed. Reimbursement is subject to the following limits:

- **$2,000 per covered service maximum** – whether the related medical service is received from a network or out-of-network provider or facility – for qualifying transportation and lodging expenses incurred by the plan participant receiving the covered service (the patient) and the eligible caregiver(s).
- A combined **overall lifetime maximum of $10,000** per covered plan participant when traveling as the patient receiving the covered medical service.
  - The same limit applies whether the related medical service is received from a network or out-of-network provider or facility.
  - The limit applies to qualifying transportation and lodging expenses incurred by the patient and the eligible caregiver(s), combined.
  - This lifetime maximum benefit aggregates the qualifying travel expense reimbursements accumulated while you're an eligible participant in the Chevron Medical PPO Plan, the Chevron High Deductible Health Plan (HDHP), the High Deductible Health Plan Basic (HDHP Basic), the Mental Health and Substance Use Disorder (MHSUD) Plan, or any combination thereof.
- Qualifying charges for reasonable and necessary **lodging expenses** for the patient (while not confined) and caregiver are *also* subject to the current IRS per diem limit, as defined in Publication 502. As of the writing of this publication, those limits are as follows:
  - For covered adult patients, the per diem rate is up to **$50** for one person or up to **$100** per day for a patient and one caregiver, combined.
  - If the patient is a covered dependent minor child, the transportation expenses of two caregivers will be covered, but lodging will be reimbursed up to the **$100** per diem rate for the patient and both caregivers, combined.

how to use the travel benefit

Follow these steps to request reimbursement for qualifying travel expenses under this plan provision.

Step 1: Plan ahead, when possible

- Be sure to read these plan rules for the travel benefit to ensure you are meeting all requirements to be eligible for reimbursement. If you have questions, contact Anthem.
- Remember that the health service you or an enrolled dependent receives must be a *covered medical service* under the Medical PPO. If your coverage for the service is denied, you cannot request reimbursement for travel expenses. **For this reason, you are strongly encouraged to contact Anthem in advance, when possible, to confirm coverage for the service** and ensure you have completed any other plan requirements necessary to receive that coverage.
- You do not need to receive pre-approval to use the *travel* benefit, but if your covered medical service requires prior authorization, you will need to complete these normal benefit requirements to receive coverage for the service. If the medical service isn't covered, your travel expenses aren't covered.
- You'll need to make your own travel and lodging arrangements.
- Anthem can help you locate a network provider or facility. You can choose any provider or facility but using a network provider or facility can save you money on your out-of-pocket costs for the medical service.
- Keep in mind that you can't be reimbursed for qualifying travel expenses in *advance* of receiving the medical service, even if you've prepaid for air or train tickets and lodging.
- You are responsible for the payment of services rendered. Anthem will reimburse you directly, not the transportation or lodging provider.

Step 2: Receive care, save your receipts

When you submit a claim for reimbursement of qualifying travel expenses, you will be required to provide a valid receipt for all transportation and/or lodging expenses. Be sure that your receipts are itemized and legible. Itemization includes, but is not limited to: name, date, time, amounts, and purpose. Credit card statements are not acceptable as documentation, so be sure to collect proper documentation at each step of your journey. You should also make a copy of all receipts and itemized bills as originals will not be returned to you.

Step 3: Submit a *medical* claim for the covered service, first

The related qualifying **medical claim** for the covered service must be on file with and approved by Anthem *before* you can submit a claim for reimbursement of travel expenses. As a reminder, if the service was received from a network provider or facility, the provider or facility will file a medical claim for you. If the service was received from an out-of-network provider or facility, it is your responsibility to file a medical claim with Anthem. You can learn how to file a medical claim or check the status of a medical claim:

- From your Anthem website account at **www.anthem.com/ca**
- From the Anthem **Sydney Health** mobile app
- By calling Anthem at **1-844-627-1632**

Step 4: Submit a travel claim for the travel expenses, last

You can submit a claim for reimbursement of qualifying **travel expenses** after Anthem has approved your claim for the related medical service. *Do not* use the standard medical claim form or the Anthem website to submit a travel benefit claim. You must use the **Claim for Reimbursement of Travel Expenses** paper form specifically for this reimbursement. Complete submission instructions are included on the form. Your reimbursement will be paid from Anthem by check after processed. You can get the special travel benefit claim form:

- From the **Forms Library** on **hr2.chevron.com (or hr2.chevron.com/retiree)**
- From your Anthem website account at **www.anthem.com/ca**
- By calling Anthem at **1-844-627-1632**

As a reminder, your signature on the **Claim for Reimbursement of Travel Expenses** form attests to the accuracy and completeness of all information on the form, including the receipts, and that you acknowledge that any material omission or misrepresentation of facts may result in the denial of benefits, termination of coverage for you and your dependents and/or disciplinary action including and up to termination of employment. It also authorizes the release of your medical records by the provider to Anthem, if necessary.

out-of-pocket maximum clarification

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*.

There is an error in the **Medical Out-of-Pocket Maximum Feature** section of the Medical PPO Plan summary plan description. The bullet included below was *incorrectly* included on the listing for “The following expenses do not count toward the medical and mental health services out-of-pocket maximum amount …” and should be disregarded.

- Your share of the cost for services and supplies under the Mental Health and Substance Abuse Plan.

high deductible health plan (HDHP)

annual combined deductible

The Chevron HDHP has one **combined deductible** for medical, prescription drugs (both retail and mail-order), mental health and substance use disorder services. This means you'll have to pay the full cost for covered services and supplies until you reach the deductible for the year.

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.

Effective **January 1, 2023**, the annual combined deductible for the HDHP for covered services received from a **network** and **out-of-network provider** will increase as shown below.

Combined medical, prescription drug, mental health and substance use disorder services

Coverage Category	Network	Out-of-network
You Only	$3,000	$6,000
You + One Adult*	$6,000	$12,000
You + Child(ren)*	$6,000	$12,000
You + Family*	$6,000	$12,000

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

high deductible health plan (HDHP)
high deductible health plan basic (HDHP Basic)

expanded travel reimbursement benefit for covered medical services

overview

The HDHP and HDHP Basic *currently* covers the cost of transportation and lodging only for certain emergencies and organ and tissue transplants. **Effective August 1, 2022, the HDHP and HDHP Basic now also include an expanded travel expense reimbursement benefit for all covered medical services if you cannot access the care you need where you live.** The benefit applies to a covered service received on or after August 1, 2022, and for travel to obtain that service on or after August 1, 2022.

how it works

This plan provision reimburses you for charges incurred for reasonable, qualifying travel expenses that are essential to receive any covered medical service under the HDHP or HDHP Basic. To be eligible for reimbursement, **all** of the following requirements must be satisfied:

- **The covered service is not reasonably available to you from a network provider or facility within 100 miles of your home residence.**
  Reasonably available might include – but is not limited to – when there are no network providers or facilities who offer the service in your area, or you cannot get an appointment within a reasonable time based on your health situation.

- **The health care must be a covered medical service under the HDHP or HDHP Basic.**
  - If the related medical service is not covered or benefits are denied, travel expenses will not be covered.
  - Note that this benefit only provides reimbursement for qualifying travel expenses; the cost of the covered service continues to be covered as per the plan's normal schedule of medical benefits and is separate from this travel benefit plan provision.
  - Reimbursement for eligible travel expenses is only available under the HDHP or HDHP Basic. This plan provision *does not* apply to covered prescription drugs under the Chevron Prescription Drug Program or basic vision services under the Chevron Vision Program.
  - Travel expense reimbursement for organ and tissue transplant services are ineligible for reimbursement under this plan provision because they are already covered under the existing Organ and Tissue Transplant provision.
  - Travel expense reimbursements for online visits are also ineligible for reimbursement under this plan provision because this service can be accessed without the requirement to travel.

- **The expense must be a covered, qualifying travel expense.**
  In general, qualifying travel expenses for non-emergency transportation and/or lodging must be essential to obtain a covered medical service and are incurred by an enrolled participant (the patient) and caregiver, if any. See the *Qualifying Travel Expenses* section below for further details.

- **The qualifying expenses are incurred by the plan participant receiving the covered service - the patient - and eligible caregiver(s), if any.**
  To receive reimbursement for qualifying travel expenses, an eligible *caregiver* must meet **both** of the following requirements:
  - The caregiver is a person who can give injections, medications, or other treatment required by the patient who is unable to travel alone to receive the covered service.
  - The caregiver(s) must travel with the patient on the same day(s) to and from the site where the service is provided.

  If the patient is a dependent child enrolled in the HDHP or HDHP Basic, the qualifying travel expenses of up to **two** caregivers will be covered – a parent who must accompany the child and another caregiver. For adult patients, qualifying travel expenses for **one** caregiver will be covered.

- **Reimbursement is subject to IRS and plan reimbursement limits.**
  You are limited in the amount of reimbursement you can receive for qualifying travel expenses. Amounts in excess of any applicable limits will not be reimbursed. See the *Reimbursement Limits* section below for further details.

- **Reimbursement is subject to the annual combined deductible.**
  Qualifying travel expenses will be subject to the applicable annual combined deductible for the HDHP or HDHP Basic. Benefits for the covered medical service will continue to follow the HDHP and/or HDHP Basic's normal deductible and coinsurance schedule.

- **The covered service must be received in the United States*, from either a network or out-of-network provider or facility.**
  While you are strongly encouraged to use a network provider or facility whenever possible, there is no network requirement to receive reimbursement under this plan provision.
  ** Includes a territory or possession under the jurisdiction of the United States.*

- **Properly completed travel claim(s) for reimbursement, including documentation, are submitted by the plan's claim filing deadline.**
  Submit your travel benefit claim as soon as possible after your related medical claim is approved. You must file a claim for reimbursement of travel expenses no later than six months (by June 30) following the calendar year in which the covered service was provided. If you don't file a proper claim within this time frame, travel expenses for the related covered service will be denied. Refer to the HDHP or HDHP Basic summary plan description for more information about claim filing limitations and exclusions. See the *How to Use the Travel Benefit* section later in this document for further instructions about the travel claim process.

qualifying travel expenses

For purposes of this plan provision, qualifying travel expenses are generally non-emergency **Lodging** and **Transportation** expenses for *medical care* for which you could have claimed a tax deduction on an itemized federal income tax return. Guidance for what constitutes such an expense may be found in **IRS Publication 502 – Medical and Dental Expenses**. In general, qualifying transportation and/or lodging expenses must be essential to obtain a covered medical service and are incurred by an enrolled participant (the patient) and caregiver, if any.

General examples of **qualifying travel expenses** include but are not limited to:

- Mileage in your personal car to/from your home to the covered service provider or facility
- Rental cars
- Train or airline travel tickets
- Bus, shuttle, taxi and ride share services
- Lodging not provided by a hospital or other institution for the patient and caregiver, subject to IRS per diem limits
- Gas
- Tolls
- Long-term airport parking or other parking fees

Qualifying travel expenses do not include meals, personal use items (laundry, telephone calls, vehicle maintenance, etc.) or other travel expenses that relate to travel that is merely beneficial to general health and unrelated to a covered service, such as a vacation or personal trip. They also don't include amounts you pay for the care of children, even if the expenses enable you, your spouse or domestic partner, or your dependent to receive a covered medical service.

Review IRS Publication 502 available online at www.irs.gov for complete details about what are and are not qualifying expenses.

reimbursement limits

Under this provision, you are limited in the amount of reimbursement you can receive for qualifying transportation and lodging expenses. Amounts in excess of any applicable limits will not be reimbursed. Reimbursement is subject to the following limits:

- **$2,000 per covered service maximum** – whether the related medical service is received from a network or out-of-network provider or facility – for qualifying transportation and lodging expenses incurred by the plan participant receiving the covered service (the patient) and the eligible caregiver(s).
- A combined **overall lifetime maximum of $10,000** per covered plan participant when traveling as the patient receiving the covered medical service.
  - The same limit applies whether the related medical service is received from a network or out-of-network provider or facility.
  - The limit applies to qualifying transportation and lodging expenses incurred by the patient and the eligible caregiver(s), combined.
  - This lifetime maximum benefit aggregates the qualifying travel expense reimbursements accumulated while you're an eligible participant in the Chevron Medical PPO Plan, the Chevron High Deductible Health Plan (HDHP), the High Deductible Health Plan Basic (HDHP Basic), the Mental Health and Substance Use Disorder (MHSUD) Plan, or any combination thereof.
- Qualifying charges for reasonable and necessary **lodging expenses** for the patient (while not confined) and caregiver are *also* subject to the current IRS per diem limit, as defined in Publication 502. As of the writing of this publication, those limits are as follows:
  - For covered adult patients, the per diem rate is up to **$50** for one person or up to **$100** per day for a patient and one caregiver, combined.
  - If the patient is a covered dependent minor child, the transportation expenses of two caregivers will be covered, but lodging will be reimbursed up to the **$100** per diem rate for the patient and both caregivers, combined.

how to use the travel benefit

Follow these steps to request reimbursement for qualifying travel expenses under this plan provision.

Step 1: Plan ahead, when possible

- Be sure to read these plan rules for the travel benefit to ensure you are meeting all requirements to be eligible for reimbursement. If you have questions, contact Anthem.
- Remember that the health service you or an enrolled dependent receives must be a *covered medical service* under the HDHP or HDHP Basic. If your coverage for the service is denied, you cannot request reimbursement for travel expenses. **For this reason, you are strongly encouraged to contact Anthem in advance, when possible, to confirm coverage for the service** and ensure you have completed any other plan requirements necessary to receive that coverage.
- You do not need to receive pre-approval to use the *travel* benefit, but if your covered medical service requires prior authorization, you will need to complete these normal benefit requirements to receive coverage for the service. If the medical service isn't covered, your travel expenses aren't covered.
- You'll need to make your own travel and lodging arrangements.
- Anthem can help you locate a network provider or facility. You can choose any provider or facility but using a network provider or facility can save you money on your out-of-pocket costs for the medical service.
- Keep in mind that you can't be reimbursed for qualifying travel expenses in *advance* of receiving the medical service, even if you've prepaid for air or train tickets and lodging.
- You are responsible for the payment of services rendered. Anthem will reimburse you directly, not the transportation or lodging provider.

Step 2: Receive care, save your receipts

When you submit a claim for reimbursement of qualifying travel expenses, you will be required to provide a valid receipt for all transportation and/or lodging expenses. Be sure that your receipts are itemized and legible. Itemization includes, but is not limited to: name, date, time, amounts, and purpose. Credit card statements are not acceptable as documentation, so be sure to collect proper documentation at each step of your journey. You should also make a copy of all receipts and itemized bills as originals will not be returned to you.

Step 3: Submit a *medical* claim for the covered service, first

The related qualifying **medical claim** for the covered service must be on file with and approved by Anthem *before* you can submit a claim for reimbursement of travel expenses. As a reminder, if the service was received from a network provider or facility, the provider or facility will file a medical claim for you. If the service was received from an out-of-network provider or facility, it is your responsibility to file a medical claim with Anthem. You can learn how to file a medical claim or check the status of a medical claim:

- From your Anthem website account at **www.anthem.com/ca**
- From the Anthem **Sydney Health** mobile app
- By calling Anthem at **1-844-627-1632**

Step 4: Submit a travel claim for the travel expenses, last

You can submit a claim for reimbursement of qualifying **travel expenses** after Anthem has approved your claim for the related medical service. *Do not* use the standard medical claim form or the Anthem website to submit a travel benefit claim. You must use the **Claim for Reimbursement of Travel Expenses** paper form specifically for this reimbursement. Complete submission instructions are included on the form. Your reimbursement will be paid from Anthem by check after processed. You can get the special travel benefit claim form:

- From the **Forms Library** on **hr2.chevron.com (or hr2.chevron.com/retiree)**
- From your Anthem website account at **www.anthem.com/ca**
- By calling Anthem at **1-844-627-1632**

As a reminder, your signature on the **Claim for Reimbursement of Travel Expenses** form attests to the accuracy and completeness of all information on the form, including the receipts, and that you acknowledge that any material omission or misrepresentation of facts may result in the denial of benefits, termination of coverage for you and your dependents and/or disciplinary action including and up to termination of employment. It also authorizes the release of your medical records by the provider to Anthem, if necessary.

chevron prescription drug program

When you enroll in the **Medical PPO Plan**, the **High Deductible Health Plan (HDHP)**, the **High Deductible Health Plan Basic (HDHP Basic)** or the **Global Choice Plan**, you are also automatically enrolled in prescription drug coverage through the Prescription Drug Program with Express Scripts. The changes described here apply to all Prescription Drug Program participants, unless otherwise stated.

If you have questions about these plan updates, contact **Express Scripts Member Services** at **1-800-987-8368** starting October 17, 2022.

For participants enrolled in the Chevron Medical PPO Plan only:
SaveOnSP program for specialty medications

Effective **January 1, 2023**, the Express Scripts **SaveOnSP Program** will apply to Chevron Prescription Drug Program participants who are enrolled in the **Chevron Medical PPO Plan**.

- The program applies to specialty medications that are specifically identified on the **SaveOnSP drug list**, available by contacting Express Scripts.
- Specialty medications on the SaveOnSP drug list are classified as Non-Essential Health Benefits under the Affordable Care Act. **This means the cost of these drugs *will not* be applied to satisfying your out-of-pocket maximum or your deductible.**
- If you are using an affected specialty medication, Express Scripts will invite you to participate in **SaveOnSP**, to help you save money on certain specialty medications.
  - **If you choose to participate**, the program leverages available manufacturer pharmacy copay assistance, so your medication is free of charge with no copayment or coinsurance.
  - **If you decline to participate**, your medication will be subject to 30% coinsurance.
  - As a reminder, the cost of these drugs will not be applied to your deductible or out-of-pocket maximum, regardless of whether or not you choose to participate in the program.

how plan limits apply to manufacturer coupons for specialty medications

Many people use **manufacturer coupons** – also often referred to as *copay assistance* – to help lower the amount of money they pay out of pocket for their specialty medication. Effective **January 1, 2023**, the *value* of manufacturer coupons used for specialty medications dispensed by Accredo, the Express Scripts specialty pharmacy, will no longer count toward your **deductible** and **out-of-pocket maximum**. Only the amount you *actually* pay out of your own pocket will apply toward your deductible and out-of-pocket maximum.

How does this affect you?

Depending on the medication, you'll need to decide whether using a manufacturer coupon is right for you under your plan. On the one hand, it can help you spend less on your prescription. On the other, it may take you longer to meet your deductible and/or out-of-pocket maximum.

Sue uses a manufacturer coupon to help pay for a specialty medication dispensed from Accredo.

Sue's charges are as follows:

$500	Copayment
- $450	Manufacturer Coupon Value
$50	Sue pays out-of-pocket

$50, not $500 is applied toward Sue's deductible and/or out-of-pocket amount under her plan.

When you use a manufacturer coupon, at first, both the amount you paid out of pocket and the value of any manufacturer coupon you use will be applied to your deductible and out-of-pocket maximum. This means it may look like you've met your deductible and/or out-of-pocket maximum when you really haven't. After a few days, the value of your manufacturer coupon will be subtracted, and your plan limit amounts adjusted to show the correct deductible and out-of-pocket maximum under your plan. If you use specialty medications, contact Express Scripts on or after January 1, 2023, if you have questions about this change.

diabetes prevention program

Effective **December 1, 2022**, Express Scripts, in partnership with **Omada Health (Omada)**, will offer access to a diabetes prevention program to help participants at risk for type 2 diabetes. Available at no cost to eligible participants as part of the Diabetes Care Value Program℠ under your Chevron Prescription Drug Program coverage, this program is an online behavioral modification and digital care program designed to help you make gradual changes to the way you eat, move, sleep and manage stress. Included is a ready-to-use wireless scale, mobile app, support from a professional health coach, a small peer group for real-time support, weekly online lessons and interactive activities. If you meet program eligibility requirements, Omada will reach out to you directly with an invitation to participate.

enhanced musculoskeletal (MSK) care programs

Effective **January 1, 2023**, in partnership with **Hinge Health**, eligible participants will have access to free, enhanced Musculoskeletal (MSK) care programs that are personalized to best fit your MSK needs. You'll receive an invitation from Hinge Health if your claims data identifies that you're eligible to participate in the programs. Depending on the level of need, programs may include:

- Educational support focusing on key strengthening and stretching activities around healthy habits and, in some cases, live virtual sessions with a dedicated licensed physical therapist and guided rehabilitation and education.
- Personalized exercise therapy sessions guided by wearable sensors, one-on-one access to a personalized health coach, personalized education content, and behavioral health support for chronic MSK issues related to long term back and joint pain.
- Up to six virtual physical therapy sessions per episode prior to in-person healthcare provider or physical therapy care – for certain programs.

update to advanced opioid management program

Express Scripts' Advanced Opioid Management Program adds additional components to manage opioid use, including quantity and refill limits on certain medications. Effective **January 1, 2023**, quantity limits on **fentanyl patches** have been removed and a 90-day supply is no longer available.

updates to condition-specific specialty programs

The Prescription Drug Program currently has condition-specific specialty programs in place which include access to specialist pharmacists, nurses and other clinicians who are trained for your specific condition. There are programs are already in place for conditions such as hepatitis, diabetes, cancer, cholesterol, pulmonary conditions and more. Effective January 1, 2023, the following changes will occur:

- The current Inflammatory Conditions Care Value Program℠ will be expanded and renamed as the **Inflammatory + Atopic Conditions Care Value Program℠**.
- The **Neurological Care Value Program℠** – was added to your Express Scripts prescription drug coverage effective January 1, 2021. This program focuses on the growing choice of drugs to treat migraine headaches, including the high cost Calcitonin Gene Receptor Peptide Inhibitors (CGRPs). Specially trained Therapeutic Resource Center (TRC) Pharmacists are available to participants to guide the appropriate choice of drug and provide therapy consultation. The program's pharmacists will also proactively outreach to support drug adherence and training for injection administration.

You'll be notified by Express Scripts if your condition and medication is subject to any of these programs during 2023, including what you need to do, if anything.

mango health solution access ends

Express Script's partnership with **Mango Health Solutions** has ended. Mango health Solutions was a third-party provider for tools and resources under certain Express Programs, such as the Pulmonary Care Value Program℠. If this change affects your participation in an Express Scripts Program, you'll be contacted directly with further information.

coverage for over-the-counter, at-home COVID-19 diagnostic tests

The Prescription Drug Program has been amended as required by the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). **Effective January 15, 2022, each enrolled participant in the Prescription Drug Program can receive coverage for up to eight over-the-counter, at-home COVID-19 diagnostic tests every 30 days.**

overview

If you're enrolled in the Medical PPO Plan, the High Deductible Health Plan (HDHP) or the High Deductible Health Plan Basic (HDHP Basic), your **medical coverage** through Anthem already provides coverage for COVID-19 diagnostic testing when it is considered **medically necessary** and is **ordered by a health care provider or physician**. This means that, ordinarily, an over-the-counter, at-home COVID-19 diagnostic test would qualify for coverage through Anthem *only* when such test has been ordered by a physician. **Effective January 15, 2022, you no longer need a physician's order to be reimbursed when you purchase covered at-home COVID-19 diagnostic tests through the Prescription Drug Program with Express Scripts.** [1] You can also now obtain tests online via **Express Scripts© Pharmacy** or at the pharmacy counter at an Express Scripts network pharmacy. This communication describes the rules and requirements for this coverage.

- This temporary plan rule for at-home COVID-19 diagnostic tests will expire at the end of the **COVID-19 emergency period**. As of the date of this publication, the emergency period ends April 15, 2022, but is subject to change.
- **This temporary plan rule only applies to covered at-home COVID-19 diagnostic tests that have *not* been prescribed by, ordered by, or obtained with the involvement of a health care provider or physician.** COVID-19 diagnostic testing that has been physician-ordered and/or administered by a health care provider or a health care facility continues to be covered by your medical coverage with Anthem under the Chevron Medical PPO Plan, the High Deductible Health Plan (HDHP) or the High Deductible Health Plan Basic (HDHP Basic).
- As is true with *all* reimbursements under the plan, the Prescription Drug Program cannot be used to reimburse covered at-home COVID-19 diagnostic tests that have already been reimbursed or paid under any other benefit plan or arrangement, such as your Anthem medical coverage, a health flexible spending account plan, a health savings account, or a spouse's or dependent's health plan.

[1] If you already submitted a claim for reimbursement through your medical coverage with Anthem for a covered at-home COVID-19 diagnostic test before the date of this notice, Anthem will process your reimbursement accordingly. Otherwise, all claims for tests purchased after January 15, 2022, outside of a network pharmacy or via mail order must be submitted to Express Scripts or they will be denied.

- The plan coverage described here applies to individualized diagnostic testing for COVID-19 and *not* for any other purpose including, but not limited to, public health surveillance or employment purposes (such as screening for general workplace health and safety).

covered testing products

- Covered at-home COVID-19 diagnostic tests must be purchased on or after **January 15, 2022**, to be eligible for reimbursement.
- To receive reimbursement, the test(s) must be on the **list of covered at-home COVID-19 diagnostic testing products**. Express Scripts, the claims administrator for the Chevron Prescription Drug Program, will maintain this list. Contact Express Scripts directly at **1-800-987-8368** if you have questions about products that are covered.
- You *do not* need a prescription for reimbursement of covered at-home COVID-19 diagnostic tests.

List of Covered At-Home COVID-19 Diagnostic Testing Products
As of the date of this publication, the products currently covered are included below. Please note this list is not inclusive and will change periodically as updates occur. Contact Express Scripts directly at **1-800-987-8368** for a more current list or if you have questions about products that are covered.

COVID-19 AT-HOME TEST	IHEALTH COVID-19 AG HOME TEST
INTELISWAB COVID-19 HOME TEST	ELLUME COVID-19 HOME TEST
BINAXNOW COVID-19 AG SELF TEST	ON-GO COVID-19 AG AT HOME TEST
QUICKVUE AT-HOME COVID-19 TEST	FLOWFLEX COVID-19 AG HOME TEST

quantity and time limits for coverage

Coverage for at-home COVID-19 diagnostic tests under the Prescription Drug Program is subject to a quantity and time limit, as follows:

- **Each enrolled participant** is eligible to receive coverage for **up to eight** covered tests **every 30 days**. Tests purchased that exceed this quantity and time limit are *not* reimbursable under the Prescription Drug Program.
- This requirement is measured in a **rolling 30-day period**, *not* a calendar month.
- The quantity limit applies to **individual tests**, *not* to kits. For example, if a single testing kit includes three individual tests, then three tests would be applied against your eight test limit.
- The quantity limit and the 30-day period are tracked **for each enrolled participant**, *not* for each family. For this reason, when you make a purchase or submit a claim, you'll be asked to specify for which participant the kits were purchased.
- The quantity limit and the 30-day period are tracked for each enrolled participant **regardless of where and how the tests were purchased**. For example, a participant could obtain two tests from the online Express Scripts Pharmacy, two tests from the pharmacy counter at a network pharmacy and submit a manual claim for two tests purchased from another online retailer. All six tests would be tracked toward the participant's quantity limit of eight tests every 30 days.

Keep in mind that while your benefits provide coverage for up to eight tests, your retailer or pharmacy may impose separate purchase limits on at-home COVID-19 diagnostic tests.

do you have a health account?

If your at-home COVID-19 diagnostic test *isn't* reimbursable under the Chevron Prescription Drug Program with Express Scripts, your Health Care Spending Account (HCSA) or a health savings account (HSA) may be a good reimbursement alternative. Just remember the HCSA or an HSA cannot be used to reimburse eligible expenses that have *already* been reimbursed or paid under any other benefit plan or arrangement, such as your Chevron medical or prescription drug coverage, or a spouse's or dependent's health plan.

what the program pays

As a reminder, each enrolled participant is eligible to receive up to eight covered tests every 30 days. Tests purchased that exceed this quantity and time limit are *not* reimbursable under the Prescription Drug Program. The level of reimbursement varies depending on how and where you purchased a covered test.

online express scripts© pharmacy

When purchased **online** directly from the **Express Scripts© Pharmacy**, your at-home COVID-19 tests are **free** with no shipping, copayment/coinsurance, or deductible. The system will not allow an order if a participant has exceeded the quantity and time limit. You must login to your Express Scripts account at **1-800-987-8368** and choose the **Order At-Home COVID-19 Tests** link to place your order with the online pharmacy.

pharmacy counter at a retail network pharmacy

When purchased from the *pharmacy* counter at a retail **network pharmacy**, covered test kits will be paid at **100%** with **no copayment/coinsurance** and **no deductible**. You'll need to present your Express Scripts ID card at the time of service for verification of coverage. You do not need to submit a claim. *Do not use the regular checkout lane; to receive this level of coverage you must checkout at the pharmacy counter.*

If you were charged for your test and need reimbursement

When you must submit a **manual claim to Express Scripts** to request reimbursement (either online or with the paper form), you will be reimbursed **up to $12 per test** with no deductible. You must submit a manual claim when:

- You purchase from an out-of-network pharmacy.
- You purchase from another non-Express Scripts online retailer. (For example, Amazon.com or Walmart.com.)
- You purchase from a network pharmacy, but your prescription drug coverage cannot be verified at the time of purchase. (For example, if you forget your Express Scripts ID card or you used the regular checkout lane.)
- Any other time that prescription drug coverage for covered at-home COVID-19 diagnostic tests could not be verified at the time of purchase; therefore, you paid the full cost out-of-pocket and submitted a manual claim for reimbursement from Express Scripts at a later date.

(Continued next page.)

how to submit a manual claim for reimbursement

If you had to pay the full cost of your at-home COVID-19 diagnostic test at the time of purchase, you'll need to submit a manual claim for reimbursement. Here's how:

online

- Log in to your **Express Scripts** account at **www.express-scripts.com**.
- From the **Benefits** tab on the top navigation, choose **Forms**.
- Go to the **Request Reimbursement** section to get started.
- Be sure to review the online form carefully for special instructions and tips designed to help you properly complete certain fields when making a claim for reimbursement of at-home COVID-19 diagnostic test(s).

by paper

- The **Express Scripts claim form** has been recently updated to include a special section for at-home COVID-19 test claims. Be sure to use the new form or your reimbursement could be delayed, or even denied.
- You can also access this form from the **Benefits** tab when you login to your **Express Scripts** account at **www.express-scripts.com**.

Find a network pharmacy, ask questions

- **www.express-scripts.com**
  Select your plan to locate a pharmacy or price a medication.
- Call **Express Scripts** at **1-800-987-8368**
- Network name: **National Plus Network**
- Chevron group number: **CT1839**

mental health and substance use disorder plan (MHSUD)

annual combined deductible

This change applies to Chevron Mental Health and Substance Use Disorder (MHSUD) Plan participants who are also enrolled in the High Deductible Health Plan (HDHP)

As a reminder, the Chevron HDHP has one **combined deductible** for medical, prescription drugs (both retail and mail-order), mental health and substance use disorder services. This means you'll have to pay the full cost for covered services and supplies until you reach the deductible for the year. The deductible amount for covered services is the same, regardless of if you see a network or an out-of-network provider. When you reach the HDHP network combined deductible amount, as applicable, you will also have met the MHSUD Plan's deductible and the MHSUD Plan will share the cost of covered mental health or substance use disorder services with you.

Effective **January 1, 2023**, the annual combined deductible for the HDHP for covered services received from a network provider will increase to meet federal requirements to be compatible with a health savings account. As a result, there is also a deductible increase for covered services and supplies under the MHSUD Plan.

Combined medical, prescription drug, mental health and substance use disorder services

Coverage Category	Network or Out-of-network
You Only	$3,000
You + One Adult*	$6,000
You + Child(ren)*	$6,000
You + Family*	$6,000

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

expanded travel reimbursement benefit for covered behavioral health services

This change applies to all Chevron Mental Health and Substance Use Disorder (MHSUD) Plan participants

overview

Effective August 1, 2022, the Mental Health and Substance Use Disorder (MHSUD) Plan now also includes an expanded travel expense reimbursement benefit for all covered services if you cannot access the care you need where you live. The benefit applies to a covered service received on or after August 1, 2022, and for travel to obtain that service on or after August 1, 2022.

how it works

This plan provision reimburses you for charges incurred for reasonable, qualifying travel expenses that are essential to receive any covered service under the **Chevron Mental Health and Substance Use Disorder (MHSUD) Plan** for **U.S.-payroll employees** and **expatriates on assignment in the U.S.** To be eligible for reimbursement, *all* of the following requirements must be satisfied:

- **The covered service is not reasonably available to you from a network provider or facility within 100 miles of your home residence.**
  Reasonably available might include – but is not limited to – when there are no network providers or facilities who offer the service in your area, or you cannot get an appointment within a reasonable time based on your behavioral health situation.

- **The behavioral health care must be a covered service under the MHSUD.**
  - If the related service is not covered or benefits are denied, travel expenses will not be covered.
  - Note that this benefit only provides reimbursement for qualifying travel expenses; the cost of the covered service continues to be covered as per the plan's normal schedule of behavioral health benefits and is separate from this travel benefit plan provision.
  - Travel expense reimbursements for online visits are also ineligible for reimbursement under this plan provision because this service can be accessed without the requirement to travel.

- **The expense must be a covered, qualifying travel expense.**
  In general, qualifying travel expenses for non-emergency transportation and/or lodging must be essential to obtain a covered service and are incurred by an enrolled participant (the patient) and caregiver, if any. See the *Qualifying Travel Expenses* section below for further details.

- **The qualifying expenses are incurred by the plan participant receiving the covered service - the patient - and eligible caregiver(s), if any.**
  To receive reimbursement for qualifying travel expenses, an eligible *caregiver* must meet **both** of the following requirements:
  - The caregiver is a person who can give injections, medications, or other treatment required by the patient who is unable to travel alone to receive the covered service.
  - The caregiver(s) must travel with the patient on the same day(s) to and from the site where the service is provided.

  If the patient is a dependent child enrolled in the MHSUD, the qualifying travel expenses of up to **two** caregivers will be covered – a parent who must accompany the child and another caregiver. For adult patients, qualifying travel expenses for **one** caregiver will be covered.

- **Reimbursement is subject to IRS and plan reimbursement limits.**
  You are limited in the amount of reimbursement you can receive for qualifying travel expenses. Amounts in excess of any applicable limits will not be reimbursed. See the *Reimbursement Limits* section below for further details.

- **Reimbursement may be subject to the annual deductible, depending on your medical coverage.**
  - For MHSUD participants enrolled in the Medical PPO Plan, a Medical HMO, Global Choice or waiving Chevron medical coverage, qualifying travel expenses *are not* subject to the deductible.
  - For MHSUD participants enrolled in the High Deductible Health Plan or the High Deductible Health Plan Basic, there is one combined deductible for medical, prescription drugs, mental health and substance use disorder services. Qualifying travel expenses *are* subject to the applicable annual combined deductible.
  - As a reminder, benefits for the covered behavioral health service will continue to follow the MHSUD's normal deductible, coinsurance or copayment schedule.

- **The covered service must be received in the United States*, from either a network or out-of-network provider or facility.**
  While you are strongly encouraged to use a network provider or facility whenever possible, there is no network requirement to receive reimbursement under this plan provision.
  ** Includes a territory or possession under the jurisdiction of the United States.*

- **Properly completed travel claim(s) for reimbursement, including documentation, are submitted by the plan's claim filing deadline.**
  Submit your travel benefit claim as soon as possible after your related behavioral health claim is approved. You must file a claim for reimbursement of travel expenses no later than six months (by June 30) following the calendar year in which the covered service was provided. If you don't file a proper claim within this time frame, travel expenses for the related covered service will be denied. Refer to the MHSUD summary plan description for more information about claim filing limitations and exclusions. See the *How to Use the Travel Benefit* section later in this document for further instructions about the travel claim process.

qualifying travel expenses

For purposes of this plan provision, qualifying travel expenses are generally non-emergency **Lodging** and **Transportation** expenses for which you could have claimed a medical tax deduction on an itemized federal income tax return. Guidance for what constitutes such an expense may be found in **IRS Publication 502 – Medical and Dental Expenses**. In general, qualifying transportation and/or lodging expenses must be essential to obtain a covered service and are incurred by an enrolled participant (the patient) and caregiver, if any.

General examples of **qualifying travel expenses** include but are not limited to:

- Mileage in your personal car to/from your home to the covered service provider or facility
- Rental cars
- Train or airline travel tickets
- Bus, shuttle, taxi and ride share services
- Lodging not provided by a hospital or other institution for the patient and caregiver, subject to IRS per diem limits
- Gas
- Tolls
- Long-term airport parking or other parking fees

Qualifying travel expenses do not include meals, personal use items (laundry, telephone calls, vehicle maintenance, etc.) or other travel expenses that relate to travel that is merely beneficial to general health and unrelated to a covered service, such as a vacation or personal trip. They also don't include amounts you pay for the care of children, even if the expenses enable you, your spouse or domestic partner, or your dependent to receive a covered service.

Review IRS Publication 502 available online at www.irs.gov for complete details about what are and are not qualifying expenses.

reimbursement limits

Under this provision, you are limited in the amount of reimbursement you can receive for qualifying transportation and lodging expenses. Amounts in excess of any applicable limits will not be reimbursed. Reimbursement is subject to the following limits:

- **$2,000 per covered service maximum** – whether the related behavioral health service is received from a network or out-of-network provider or facility – for qualifying transportation and lodging expenses incurred by the plan participant receiving the covered service (the patient) and the eligible caregiver(s).
- A combined **overall lifetime maximum of $10,000** per covered plan participant when traveling as the patient receiving the covered service.
  - The same limit applies whether the related behavioral health service is received from a network or out-of-network provider or facility.
  - The limit applies to qualifying transportation and lodging expenses incurred by the patient and the eligible caregiver(s), combined.
  - This lifetime maximum benefit aggregates the qualifying travel expense reimbursements accumulated while you're an eligible participant in the Chevron Medical PPO Plan, the Chevron High Deductible Health Plan (HDHP), the High Deductible Health Plan Basic (HDHP Basic), the Mental Health and Substance Use Disorder (MHSUD) Plan, or any combination thereof.
- Qualifying charges for reasonable and necessary **lodging expenses** for the patient (while not confined) and caregiver are *also* subject to the current IRS per diem limit, as defined in Publication 502. As of the writing of this publication, those limits are as follows:
  - For covered adult patients, the per diem rate is up to **$50** for one person or up to **$100** per day for a patient and one caregiver, combined.
  - If the patient is a covered dependent minor child, the transportation expenses of two caregivers will be covered, but lodging will be reimbursed up to the **$100** per diem rate for the patient and both caregivers, combined.

how to use the travel benefit

Follow these steps to request reimbursement for qualifying travel expenses under this plan provision.

Step 1: Plan ahead, when possible

- Be sure to read these plan rules for the travel benefit to ensure you are meeting all requirements to be eligible for reimbursement. If you have questions, contact Beacon Health Options.
- Remember that the health service you or an enrolled dependent receives must be a *covered service* under the MHSUD. If your coverage for the service is denied, you cannot request reimbursement for travel expenses. **For this reason, you are strongly encouraged to contact Beacon Health Options in advance, when possible, to confirm coverage for the service** and ensure you have completed any other plan requirements necessary to receive that coverage.
- You do not need to receive pre-approval to use the *travel* benefit, but if your covered behavioral health service requires prior authorization, you will need to complete these normal benefit requirements to receive coverage for the service. If the behavioral health service isn't covered, your travel expenses aren't covered.
- You'll need to make your own travel and lodging arrangements.
- Beacon Health Options can help you locate a network provider or facility. You can choose any provider or facility but using a network provider or facility can save you money on your out-of-pocket costs for the behavioral health service.
- Keep in mind that you can't be reimbursed for qualifying travel expenses in *advance* of receiving the behavioral health service, even if you've prepaid for air or train tickets and lodging.
- You are responsible for the payment of services rendered. Beacon Health Options will reimburse you directly, not the transportation or lodging provider.

Step 2: Receive care, save your receipts

When you submit a claim for reimbursement of qualifying travel expenses, you will be required to provide a valid receipt for all transportation and/or lodging expenses. Be sure that your receipts are itemized and legible. Itemization includes, but is not limited to: name, date, time, amounts, and purpose. Credit card statements are not acceptable as documentation, so be sure to collect proper documentation at each step of your journey. You should also make a copy of all receipts and itemized bills as originals will not be returned to you.

Step 3: Submit a *behavioral health* claim for the covered service, first

The related qualifying behavioral health claim for the covered service must be on file with and approved by Beacon Health Options *before* you can submit a claim for reimbursement of travel expenses. As a reminder, if the service was received from a network provider or facility, the provider or facility will file a behavioral health claim for you. If the service was received from an out-of-network provider or facility, it is your responsibility to file a claim with Beacon Health Options. You can file a claim or check the status of a behavioral health claim:

- Download the form on the **Forms Library** at **hr2.chevron.com (or hr2.chevron.com/retiree)**.
- Call Beacon Health Options at **1-800-847-2438** (714-763-2420 outside the U.S.)

Step 4: Submit a travel claim for the travel expenses, last

You can submit a claim for reimbursement of qualifying travel expenses after Beacon Health Options has approved your claim for the related behavioral health service. *Do not* use the standard behavioral health claim form or the Beacon Health Options website to submit a travel benefit claim. You must use the **MHSUD Claim for Reimbursement of Travel Expenses** paper form *specifically* for this reimbursement. Complete submission instructions are included on the form. Your reimbursement will be paid from Beacon Health Options after processing. You can get the special travel benefit claim form:

- From the **Forms Library** on **hr2.chevron.com (or hr2.chevron.com/retiree)**.

As a reminder, your signature on the **MHSUD Claim for Reimbursement of Travel Expenses** form attests to the accuracy and completeness of all information on the form, including the receipts, and that you acknowledge that any material omission or misrepresentation of facts may result in the denial of benefits, termination of coverage for you and your dependents and/or disciplinary action including and up to termination of employment. It also authorizes the release of your health records by the provider to Beacon Health Options, if necessary.

dental PPO plan

annual deductible

If you choose to go to an **out-of-network provider**, you must pay required deductible before plan benefits can be paid for **Basic** and **Major Dental Care**. No deductible is required for **Preventive and Diagnostic Care**, **Orthodontic Care**, or **Non-Surgical TMJ** out-of-network services. You're also required to pay any difference between your dentist's charge and the plan's reimbursement, which is based on the dental allowance charges. (This is often referred to as *balanced billing*.)

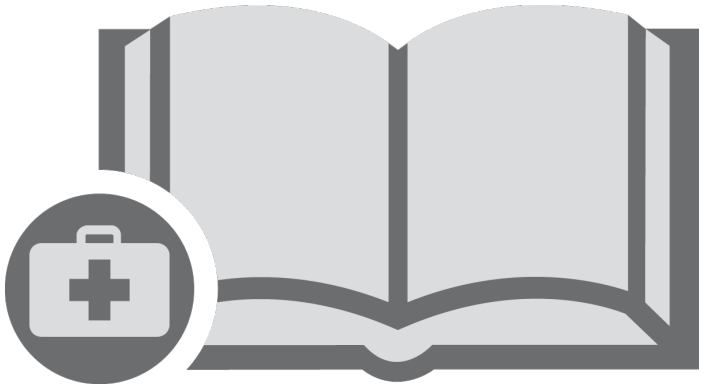
Effective **January 1, 2023**, the annual deductible for the Dental PPO for covered services received from an **out-of-network provider** will be streamlined, as indicated below.

Annual Deductible for Basic and Major Dental Care services

Coverage Category	Network	Out-of-network
You Only	$0 No deductible for network covered services.	$100
You + One Adult*		$200
You + Child(ren)*		$200
You + Family*		$200 *(↓ $100)*

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

annual health benefit notices



Here are notices that Chevron is legally-required to provide to you regarding your health benefits. No further action is required from you.

Your Rights After a Mastectomy – Women's Health and Cancer Rights Act of 1998

If you have had a mastectomy or expect to have one, you may be entitled to special rights under the Women's Health and Cancer Rights Act of 1998 (WHCRA). The WHCRA requires health plans to provide certain benefits for reconstructive surgery in connection with a mastectomy. You may need to contact your medical plan or your HMO before any reconstructive surgery to make sure you qualify for full benefits. Consistent with the WHCRA, 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.

The Mental Health and Substance Use Disorder Plan (MHSUD) is a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act

Chevron Corporation believes the Chevron Corporation Mental Health and Substance Use Disorder Plan (the MHSUD Plan) is a grandfathered health plan under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 1-888-825-5247. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Notice of Privacy Practices for Health Care Information (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information in accordance with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). You can review a current version of this notice in the Legal Notices section on **hr2.chevron.com**.

Notice Regarding Wellness Program

This notice applies to health information that may be collected when you participate in Chevron's wellness programs, including how it's collected, how it's used, who will receive it, and what will be done to keep it confidential. You can review a current version of this notice in the **Legal Notices** section on **hr2.chevron.com**.

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 the **Legal Notices** section on **hr2.chevron.com**.

- 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 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.

Your Right to Receive Continuation of Care – No Surprises Act

This information about the *Continuity of Care* provision of the No Surprises Act, a consumer protection law that applies when a provider ceases to be a network provider during an ongoing course of treatment. This information is provided for your awareness only; your action is not required. This legislation applies to all covered participants in all Chevron-sponsored medical, prescription drug, mental health and substance use disorder plans. If you have questions about this information, contact your health plan directly for assistance.

In general, under the No Surprises Act, if your provider or facility leaves your health plan's network, coverage for continued transitional care from that provider or facility at the network level of benefits may be available to you for up to 90 days. As a consumer, you should know that:

- You must satisfy certain defined conditions to be eligible for continuity of care. Continuity of Care generally, applies to hospitalization, a course of institutional care, scheduled to undergo nonelective surgery, pregnancy, and treatment for a serious and complex condition.
- Your health plan claims administrator is required to timely notify continuing care patients of network terminations affecting your provider or facility and your right to elect continued transitional care from your provider or facility.
- Continuation of care is not automatic. You will generally be required to apply for this transition care by following your health plan claims administrator's application process.

If you want to learn more about Continuation of Care, including eligibility requirements or how to apply, contact your health plan's claims administrator directly.

Your Rights and Protections Against Surprise Medical Bills – No Surprises Act

This information about the *Surprise Billing* provision of the No Surprises Act, a consumer protection law that helps curb the practice known as surprise billing for medical care. This information is provided for your awareness only; your action is not required. This legislation applies to all covered participants in all Chevron-sponsored medical, prescription drug, mental health and substance use disorder plans. If you have questions about this information, contact your health plan directly for assistance.

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is *balance billing* (sometimes called *surprise billing*)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

Out-of-network describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called *balance billing*. This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

Surprise billing is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services. If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center. When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you think you've been wrongly billed, you can contact the Employee Benefits Security Administration (EBSA), the No Surprise Help Desk (NSHD) at 1-800-985-3059 or https://www.cms.gov/nosurprises/consumers, or your State Regulator, if your plan is fully insured, to ask whether the charges are allowed by law.

Chevron
Human Resources Service Center
PO Box 981901
El Paso, TX 79998

Address Service Requested