chevron benefit plan changes

effective january 1, 2024

(unless otherwise indicated)

for COBRA participants

sign up for electronic delivery

NEW! Sign up for electronic delivery of your Chevron COBRA benefit information at any time from the **BenefitConnect | COBRA website** website.

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. 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. Unless required by applicable law, there are no vested rights with respect to any Chevron health and welfare plan benefit or to any company contributions towards the cost of such health and welfare plan benefits. 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

If you haven't already, make open enrollment elections for your 2024 Chevron COBRA coverage. **Open enrollment is November 1 through November 15, 2023.** Any elections you make for your COBRA coverage during open enrollment become effective January 1, 2024. This newsletter provides information about changes to your COBRA benefits and how to enroll.

Be sure to learn about the changes coming to your 2024 benefits prior to making open enrollment elections. Information about plan changes are included in this document. In addition, watch for these important communications to arrive under separate cover from **BenefitConnect | COBRA**:

- A personalized, **2024 COBRA Enrollment Notice** in late October. This package will include:
  - Information about accessing the BenefitConnect | COBRA enrollment website.
  - Detailed instructions for making COBRA open enrollment elections.
  - A personalized 2024 COBRA Premium Rate sheet that provides premium costs, plan choices and the coverage levels available to you.
- A **COBRA Payment Coupon** packet in December. This package will include:
  - A monthly coupon book you'll use to mail your 2024 premium payments.

how to enroll
november 1 through november 15, 2023

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, 2023**.

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, 2023**.

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 2024 for 2025 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, 2023**, become effective January 1, 2024.

you must act
november 1 - november 15, 2023 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 2024 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 2024, 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**.

2024 chevron COBRA benefit changes

Update to the summary plan descriptions (SPD)

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:

2024 Plan Changes

- Medical PPO Plan
- High Deductible Health Plan
- High Deductible Health Plan Basic
- Prescription Drug Program
- Mental Health and Substance Use Disorder Plan (MHSUD)
- Dental PPO Plan

2023 Mid-Year Plan Changes

- Medical PPO Plan
- High Deductible Health Plan
- High Deductible Health Plan Basic
- Prescription Drug Program
- Medical HMO - Kaiser Northern and Southern CA
- Mental Health and Substance Use Disorder Plan (MHSUD)

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.

anthem inclusive care
part of the total health total you program
effective january 1, 2024

Update to the summary plan description (SPD)
All changes described in this SMM are effective January 1, 2024.

The enclosed information serves as an official summary of material modification (SMM) for participants enrolled in the **Chevron Medical PPO Plan,** the **High Deductible Health Plan (HDHP)** and the **High Deductible Health Plan Basic (HDHP Basic)**. 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 **hr2.chevron.com/retiree**) or by calling the HR Service Center at **1-888-825-5247**.

total health total you program update: inclusive care

Anthem Inclusive Care

For your information, effective January 1, 2024, **Anthem Inclusive Care**, offered as part of the **Total Health Total You Program**, has been added to your medical coverage. With Anthem Inclusive Care, you'll have access to specially trained Health Guides with an increased knowledge and understanding of LGBTQ+ concerns who can identify medical doctors who are familiar with and experienced in providing LGBTQ+ healthcare. If you are interested in exploring gender affirming care, a Health Guide can also connect you to the Inclusive Care Team for confidential counseling and guidance through the process. This team will help you understand your benefits, find a surgery center near you, coordinate multiple service providers, and in some cases arrange travel. If you think Inclusive Care could help you, contact **Anthem** any time after January 1, 2024, at **1-844-627-1632**.

What is the Total Health Total You Program?

Anthem, the claims administrator for the Medical PPO, HDHP and HDHP Basic, may provide voluntary clinical support programs from time to time. The **Total Health Total You Program** generally provides personalized guidance in the form of provider recommendations, alternative care options, condition support and education, benefits information, health program recommendations, and more. These not only support your overall health and wellness, but also a wide array of clinical health conditions, such as asthma, diabetes, coronary artery disease and others. With oversight from Chevron, Anthem has the authority to add, expand or eliminate offerings under the Total Health Total You Program at any time as part of their responsibilities as a claims administrator.

annual combined deductible

high deductible health plan (HDHP)

effective january 1, 2024

Update to the summary plan description (SPD)
All changes described in this SMM are effective January 1, 2024.

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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, 2024**, 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	$3,200	$6,400
You + One Adult*	$6,400	$12,800
You + Child(ren)*	$6,400	$12,800
You + Family*	$6,400	$12,800

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

hypertension remote monitoring program
new condition-specific specialty program

chevron prescription drug program
effective january 1, 2024

Update to the summary plan descriptions (SPD)
Changes described in this SMM are effective January 1, 2024.

The enclosed information serves as an official summary of material modification (SMM) for the **Prescription Drug Program**, automatically included for participants enrolled in the **Chevron Medical PPO Plan,** the **High Deductible Health Plan (HDHP)** the **High Deductible Health Plan Basic (HDHP Basic)** and the **Global Choice Plan**. 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 **hr2.chevron.com/retiree**) or by calling the HR Service Center at **1-888-825-5247**.

condition-specific specialty program update

What is a condition-specific specialty program?

The Prescription Drug Program includes provisions that allow the claims administrator – Express Scripts – to identify and provide plan participants with access to a variety of specialized services and support tools that are specific to certain health conditions. These are referred to as **condition-specific specialty programs**. These programs generally provide *additional* access to services and don't usually affect your current prescription drug benefit. In general, these programs support your adherence to medication treatments. Studies show that adhering to proper and consistent medication therapies can help you avoid hospital visits or a recurrence of dangerous symptoms and complications. There are currently programs already in place for conditions such as hepatitis, diabetes and pre-diabetes, cancer, cholesterol, pulmonary conditions, neurological conditions and more. With oversight from Chevron, Express Scripts has the authority to add, expand or eliminate these programs at any time as part of their responsibilities as a claims administrator.

Hypertension Remote Monitoring Program

For your information, effective January 1, 2024, Hypertension Remote Monitoring, a condition-specific specialty program, has been added to your Express Scrips prescription drug coverage. This program provides clinically targeted members a connected blood pressure cuff and mobile app to easily track their readings. With each reading, the member receives instant in-app feedback and coaching to drive them closer to their goal. In addition, members have access to a clinical coaching team who provide counseling on ways to keep their blood pressure well controlled, adhering to their medications and generally managing their hypertension through lifestyle changes.

If you have questions about this or other condition-specific specialty programs, contact **Express Scripts Member Services** at **1-800-987-8368** starting October 16, 2024.

inmynd behavioral health
new condition-specific specialty program
chevron prescription drug program
effective january 1, 2024

Update to the summary plan descriptions (SPD)
Changes described in this SMM are effective January 1, 2024.

The enclosed information serves as an official summary of material modification (SMM) for the **Prescription Drug Program**, automatically included for participants enrolled in the **Chevron Medical PPO Plan,** the **High Deductible Health Plan (HDHP)** the **High Deductible Health Plan Basic (HDHP Basic)** and the **Global Choice Plan**. 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 **hr2.chevron.com/retiree**) or by calling the HR Service Center at **1-888-825-5247**.

condition-specific specialty program update

What is a condition-specific specialty program?

The Prescription Drug Program includes provisions that allow the claims administrator – Express Scripts – to identify and provide plan participants with access to a variety of specialized services and support tools that are specific to certain health conditions. These are referred to as **condition-specific specialty programs**. These programs generally provide *additional* access to services and don't usually affect your current prescription drug benefit. In general, these programs support your adherence to medication treatments. Studies show that adhering to proper and consistent medication therapies can help you avoid hospital visits or a recurrence of dangerous symptoms and complications. There are currently programs already in place for conditions such as hepatitis, diabetes and pre-diabetes, cancer, cholesterol, pulmonary conditions, neurological conditions and more. With oversight from Chevron, Express Scripts has the authority to add, expand or eliminate these programs at any time as part of their responsibilities as a claims administrator.

InMynd Behavioral Health Program

For your information, effective January 1, 2024, the InMynd Behavioral Health Program, a condition-specific specialty program, has been added to your Express Scrips prescription drug coverage. Medications for anxiety, depression, chronic insomnia and other mental health conditions are commonly prescribed and available as part of your prescription drug benefit. InMynd is a mental health supplemental support program that complements existing behavioral health benefits, such as those offered through the Chevron Mental Health and Substance Use Disorder (MHSUD) Plan). InMynd is offered alongside other mental health counseling support and digital cognitive behavioral therapy that you may be receiving. This program focuses on the medication portion of your treatment by providing educational assistance for participants starting select new mental health medications. It also includes Specialist Pharmacists that will promote your adherence to those medications. Physicians may also receive timely adherence alerts for their patients.

If you have questions about this or other condition-specific specialty programs, contact **Express Scripts Member Services** at **1-800-987-8368** starting October 16, 2024.

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

prescription drug program

effective january 1, 2024

Update to the summary plan description (SPD)
All changes described in this SMM are effective January 1, 2024.

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.).

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

When you enroll in the Medical PPO Plan, the High Deductible Health Plan (HDHP) or the High Deductible Health Plan Basic (HDHP Basic), you are also automatically enrolled in prescription drug coverage through the Prescription Drug Program with Express Scripts. This change applies to the Prescription Drug Program for participants in the Medical PPO Plan, the High Deductible Health Plan (HDHP) and the High Deductible Health Plan Basic (HDHP Basic).

Effective January 1, 2024, each enrolled participant in the Prescription Drug Program can receive coverage for up to two over-the-counter, at-home COVID-19 diagnostic tests every 30 days from either a network pharmacy or online via the Express Scripts Pharmacy. As a reminder this coverage only applies to diagnostic tests that have not been prescribed by, ordered by, or obtained with the involvement of a health care provider or physician.

Note that the previously published *temporary* rules that permitted up to eight over-the-counter tests every 30 days from either a network pharmacy, out-of-network pharmacy or online via the Express Scripts Pharmacy expired effective December 31, 2023.

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. Effective January 1, 2024, coverage for over-the-counter, 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 may be covered through the Prescription Drug Program with Express Scripts when obtained as described in this plan rule notice.[1]

[1] If you already submitted a claim for reimbursement through Express Scripts for a covered at-home COVID-19 diagnostic test between January 15, 2022 and December 31, 2023, Express Scripts will process your reimbursement according to the rules in effect at that time. Otherwise, all claims for tests purchased on or after January 1, 2024, will be processed according to the new rules and requirements described in this notice.

- **This 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 subject to the plan rules under 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.
- 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 1, 2024**, to be eligible for reimbursement under the rules described in this notice.
- 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

(Continued next page.)

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 two** 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 two individual tests, then two tests would be applied against your two 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, suppose a participant obtains two tests from the online Express Scripts Pharmacy and then, within that subsequent 30-day period, another two tests from the pharmacy counter at a network pharmacy. The tests from the network pharmacy will not be covered because they were purchased within 30-days of the online pharmacy order. The participant's quantity limit of two tests every 30 days was exceed in this example.

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.

(Continued next page.)

what the program pays

As a reminder, each enrolled participant is eligible to receive up to two covered tests every 30 days. Tests purchased that exceed this quantity and time limit are *not* reimbursable under the Prescription Drug Program.

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.*

out-of-network retail pharmacy or other online source

The Prescription Drug Program does not provide reimbursement for covered test kits purchased on or after January 1, 2024 from an out-of-network retail pharmacy or from another non-Express Scripts online retailer. (For example, Amazon.com or Walmart.com.)

If you were charged for your test at the time of purchase

If you purchase from a network pharmacy, *but* your prescription drug coverage cannot be verified at the time of purchase, you must submit a **manual claim to Express Scripts** to request reimbursement. (For example, if you haven't yet received your ID card or the pharmacy did not accept your member ID card by mistake.)

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

(Continued next page.)

how to submit a manual claim for reimbursement

If you 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**

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. 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. Unless required by applicable law, there are no vested rights with respect to any Chevron health and welfare plan benefit or to any company contributions towards the cost of such health and welfare plan benefits. Some benefit plans and policies described in this document may be subject to collective bargaining and, therefore, may not apply to union-represented employees.

annual combined deductible

mental health and substance use disorder plan

effective january 1, 2024

Update to the summary plan descriptions (SPD)
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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, 2024**, 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	$3,200
You + One Adult*	$6,400
You + Child(ren)*	$6,400
You + Family*	$6,400

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

(continued next page)

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.

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. 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. Unless required by applicable law, there are no vested rights with respect to any Chevron health and welfare plan benefit or to any company contributions towards the cost of such health and welfare plan benefits. Some benefit plans and policies described in this document may be subject to collective bargaining and, therefore, may not apply to union-represented employees.

teledentistry (virtual visits)
dental PPO plan
effective January 1, 2024

Update to the summary plan descriptions (SPD)
All changes described in this SMM are effective January 1, 2024 unless otherwise indicated.

The enclosed information serves as an official summary of material modification (SMM) for the **Dental PPO Plan.** 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 **hr2.chevron.com/retiree** or by calling the HR Service Center at **1-888-825-5247**.

introduction of teledentistry (virtual visits)

Where state laws allow, effective January 1, 2024, the Dental PPO Plan will include coverage for **teledentistry charges for virtual visits** (photo or video) from a **network provider** for covered dental services including:

- Aftercare
- Second opinions
- Emergency consultation

Coverage for virtual visits to obtain covered dental services is also available if access to dental care is not reasonably available to an enrolled participant because of any of the following reasons:

- Geographic distance
- Transportation or ambulatory issues
- Fear or stress-related conditions that may be triggered by the sounds or smells of a dental office
- Young age (for example when a parent is unable to take time off to visit a dental office to facilitate care for the covered dependent and the child on the parent's lap during the virtual visit)

Delta Dental will reimburse for the diagnosis, consultation, or treatment of a patient delivered through teledentistry services on the same basis and to the same extent that the plan is responsible for reimbursement for the *same* service through in-person diagnosis, consultation, or treatment. Virtual assessments don't count towards exam frequency limitations and are a covered benefit for Delta Dental PPO and Delta Dental Premier members only.

contact

Contact **Delta Dental** directly at **1-800-228-0513** for more information or if you have questions effective January 1, 2024.

2023 mid-year changes

The 2023 changes included here were released earlier this year.
An additional printed copy has been provided here for your records.

update to address
agent for service of legal process
effective October 1, 2023

human energy. yours.™

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

The enclosed information serves as an official summary of material modification (SMM). 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 **hr2.chevron.com/retiree** or by calling the HR Service Center at **1-888-825-5247 (1-832-854-5800 outside the U.S.)**.

In the **Administrative Information** section of this SPD, the **Agent for Service of Legal Process** referenced address should be considered *no longer active and valid*. Please use the *new* address in place of the previous address, as instructed below.

PREVIOUS ADDRESS LISTING	REPLACEMENT ADDRESS LISTING
Agent for Service of Legal Process Any legal process related to the plans should be served on: Service of Process Chevron Corporation 6001 Bollinger Canyon Road Building T (T-3371) San Ramon, CA 94583	**Agent for Service of Legal Process** Any legal process related to the plans should be served on: CORPORATION SERVICE COMPANY WHICH WILL DO BUSINESS IN CALIFORNIA AS CSC - LAWYERS INCORPORATING SERVICE 2710 Gateway Oaks Drive Sacramento, CA 95833 1-888-690-2882

beacon health options is now carelon behavioral health

mental health and substance use disorder plan

effective march 1, 2023

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

The enclosed information serves as an official summary of material modification (SMM) for the **Mental Health and Substance Use Disorder (MHSUD) Plan**. 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 **hr2.chevron.com/retiree** or by calling the HR Service Center at **1-888-825-5247**.

carelon behavioral health

Beacon Health Options (Beacon) is the claims administrator for the **Chevron Mental Health and Substance Use Disorder (MHSUD) Plan**. On March 1, 2023, Beacon changed its name to **Carelon Behavioral Health (Carelon)**. You don't need to do anything. Your benefits and plan will not change due to this name change, you can see all of your previous doctors, and you should continue to use all phone numbers, emails, websites, and apps until otherwise instructed by Carelon.

contact

Contact **Carelon** directly at **1-800-847-2438** for more information or if you have questions.

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.

talkspace
new telebehavioral health service
mental health and substance use disorder plan
effective January 1, 2023

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 **Mental Health and Substance Use Disorder (MHSUD) Plan**. 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 **hr2.chevron.com/retiree** or by calling the HR Service Center at **1-888-825-5247**.

talkspace, another telebehavioral health service included with your coverage

Where state laws allow, the **Mental Health and Substance Use Disorder (MHSUD) Plan** already includes coverage for telebehavioral health services, through either of the following methods:

- Directly with your **existing provider** via telephone and/or secure video.
- Through a **telebehavioral health service** formally contracted as a group provider by the MHSUD claims administrator, Carelon.

Carelon currently provides contracted telebehavioral health services through MDLIVE. Effective January 1, 2023, an *additional* telebehavioral health service, **Talkspace**, is also available to employees, retirees and covered dependents eligible to participate in the MHSUD Plan.

All other rules and requirements for telebehavioral health services under the MHSUD Plan continue to apply unchanged, including these highlights:

- The MHSUD Plan's standard **deductible**, **coinsurance** or **copayment**, and **out-of-pocket maximum** plan rules and requirements are applied to your covered telebehavioral health services, as applicable.
- Telebehavioral health services are considered an outpatient treatment, so the MHSUD Plan's standard **Outpatient Office Visit** schedule of benefits will apply.
- Services be for a **covered condition** under the MHSUD Plan and be deemed medically appropriate by Carelon. Services must also be for a mental health and substance use disorder condition that Carelon has deemed **appropriate for treatment through telebehavorial health services**. Not all services, including the management of *certain* controlled medications, are appropriate for this type of remote treatment option.

- The MHSUD Plan doesn't cover **prescription drugs for outpatient treatment -** whether you're visiting a provider in the office or through one of Carelon's contracted telebehavioral health services. If you are prescribed a drug as part of your telebehavioral health service, you should check with your medical plan's prescription drug administrator to find out if it can help pay for the drugs you need; otherwise, you'll be responsible for paying the full cost of prescribed outpatient medication.

about telebehavioral health services

With confidential **telebehavioral health services**, you can use your laptop, tablet, or smartphone to visit with a counselor (therapist) or psychiatrist from your home, office, or on-the-go. Depending on the service you use, counselors and prescribers are available by phone or secure video, chat, or messaging to address:

- Stress management
- Relationship issues
- Mental health conditions such as depression and anxiety
- Life changes including trauma and grief, identity struggles, and sleep
- Substance use disorders and other addictive behaviors
- Eating disorders
- ADHD
- Medication evaluation and management (may not be available for certain medications)
- and more …

how to use the talkspace service

To use telebehavioral health services through **Talkspace**:

- **Step One:** Register for a Talkspace account.
- **Step Two:** Complete the QuickMatch™ questionnaire to share your preferences and review your best personal provider match.
- **Step Three:** Schedule a telebehavioral health appointment from your Talkspace account.
- **Step Four:** Access your Talkspace account at your scheduled appointment time. Appointments can be done from your computer connected to the internet from the secure Talkspace website or from your mobile device through the app.

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How to register your Talkspace account

To register for this service, you will need your **Carelon Member ID or Subscriber ID**. Your Carelon Member ID is NOT on your health insurance ID card. Your Member ID/Subscriber ID is your **Chevron Worker ID**. This is a unique identifier that's provided to all employees. You can call Beacon to get this number or, if you are an active employee, you can locate your Worker ID through Workday (generally requires Chevron intranet access). Follow these instructions to locate your Chevron Worker ID or scan the QR code at right.

- Go to **talkspace.com/carelonbehavioralhealth.com**.
- Select your insurance carrier from the dropdown: **Carelon**
- Enter your **Chevron Worker ID** in the Member/Subscriber ID field. Covered dependents should also use *your* Chevron Worker ID when registering.
- Complete the **QuickMatch™** questionnaire to share your preferences and review your best personal provider match.
- Once you create an account, you can connect with a provider using the **Talkspace app** or your **computer**.

Payment at time of service

When you register for Talkspace, your answers from the QuickMatch questionnaire will also be used to determine your personal out-of-pocket cost for that telebehavioral health session. While the Talkspace system makes every effort to accurately display the most up-to-date information from Carelon, the copayment amount displayed may not be accurate and the actual amount may vary when your session is later automatically processed by Carelon. You could owe less than the copayment amount shown, or another amount up to the maximum session cost displayed. If it's determined that your out-of-pocket cost is different from what was shown online, the charge will be adjusted. Even if your copayment is $0, you'll still be required to provide a valid form of payment prior to proceeding with your telebehavioral health visit.

What's the definition of a Talkspace Session?

The cost displayed for your telebehavioral health visit is a per session cost, which is based on the MHSUD Plan's standard in-person Outpatient Office Visit schedule of benefits. A **session** is equivalent to *either* of the following:

- A **full-length live session** (video or phone)
- **Text messaging** with your Provider. (On average, text messaging sessions last 7 days.)

contact

Contact **Carelon** directly at **1-800-847-2438** for more information or for further instructions about telebehavioral health coverage and Talkspace.

(continued next page)

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.

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. 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. Unless required by applicable law, there are no vested rights with respect to any Chevron health and welfare plan benefit or to any company contributions towards the cost of such health and welfare plan benefits. Some benefit plans and policies described in this document may be subject to collective bargaining and, therefore, may not apply to union-represented employees.

important update regarding COVID-19 coverage

Chevron Medical HMO Plan - Kaiser Northern California
Chevron Medical HMO Plan - Kaiser Southern California
effective november 11, 2023

Kaiser Permanente has recently shared important changes that are coming to your COVID-19 coverage under the Chevron Medical HMO – Kaiser Northern California and Medical HMO – Kaiser Southern California. Included below, for your reference, is a copy of the plan change information Kaiser has provided to Chevron. If you have any further questions access the Kaiser website or contact Kaiser directly as indicated below.

California's mandatory waiver of member cost sharing for the COVID-19 vaccine, COVID-19 home antigen tests, PCR tests, and COVID-19 drug therapies outside the Kaiser Permanente network will end on **November 11, 2023**.

Kaiser Permanente is committed to your health, and you can continue to get COVID-19 care at no cost when you visit Kaiser Permanente.[1] That includes up to 8 home antigen tests per member, per month available at Kaiser Permanente pharmacies and through kp.org.[2] Plus, when you visit a Kaiser Permanente facility, your care team can stay up to date on your treatments through your electronic health record, ensuring you get the high-quality, personalized care you deserve.

If you choose to get a COVID-19 vaccine, testing, or drug therapy **outside** of Kaiser Permanente, you'll be responsible for cost sharing unless these services are delivered as part of covered urgent or emergency care.

You may submit claims to get reimbursed for the costs you pay for services outside the Kaiser Permanente network. Reimbursement could be less than 50% of the cost of the services provided.[3]

To submit a claim, visit **kp.org** and select **Billing** for further instructions. If you don't have online access, please call the Member Services number on the back of your membership card and ask to have a claim form mailed to you.

For more information about the end of the waiver of member copays, coinsurance, and deductibles for COVID-19 services, please visit **kp.org/covid**. If you have any questions about your coverage, please visit **kp.org/benefits** or call **1-800-464-4000** (TTY **711**).

[1] Deductibles still apply for members with a high deductible health plan.

[2] COVID-19 over the counter tests provided by the federal government, which are free, do not count toward the 8-test limit.

[3] The amount members are reimbursed will depend on the cost of the out-of-network services provided, the prevailing market rate set by California regulators, any deductible that may need to be met, and other plan limitations, consistent with the terms of your Evidence of Coverage or other plan documents.

changes to COVID-19 coverage

with end of public health emergency on may 11, 2023

As required by law, Chevron medical and prescription drug plans were required to add *temporary* coverage at no cost for various COVID-related treatments and vaccinations during the Coronavirus Public Health Emergency (which started **January 27, 2020**, and ended **May 11, 2023**).

Your Chevron medical plan continues to provide COVID-19 coverage, but your out-of-pocket costs and other plan rules may change for certain services because temporary coverage has ended.

For your reference, we've included this recap of what's changing and what's not for **Medical PPO Plan**, **High Deductible Health Plan (HDHP)** and **High Deductible Health Plan Basic (HDHP Basic)** participants. You can reference the updated SMMs enclosed with this recap. *Note:* Medical HMO participants should contact their HMO directly for COVID-19 coverage information and changes, as applicable.

what's changing … and when

COVID-19 diagnostic testing

Your plans provide coverage for COVID-19 diagnostic testing. During the Public Health Emergency qualifying tests were *not* subject to the deductible and often provided at no cost (or very little cost) to you.

COVID-19 diagnostic testing when it is considered **medically necessary** and is **ordered** by a health care provider or physician.

These tests continue to be a covered service under **Anthem**, but starting **May 12, 2023**, coverage will follow *normal* plan rules for diagnostic and laboratory testing. This means your test may be subject to the deductible and/or coinsurance, depending on the situation. If you have questions about coverage, call Anthem.

UPDATED: May 11, 2023 SMM ENCLOSED FOR MEDICAL PPO, HDHP, HDHP BASIC

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.

Temporary rules for qualifying at-home, over-the-counter tests are included under the Prescription Drug Program with Express Scripts. **Chevron has extended this temporary coverage until December 31, 2023**.

UPDATED: May 11, 2023 SMM ENCLOSED FOR PRESCRIPTION DRUG PROGRAM

COVID-19 immunizations (received from your provider or a health care facility)

Your plans provide coverage for qualifying preventive care services, including immunizations like the COVID-19 vaccine under **Anthem**. Starting **May 12, 2023**, COVID-19 immunizations will follow *normal* plan rules for preventive care services. This means your immunization is still free from a network provider, but subject to the deductible and/or coinsurance when you visit an out-of-network provider.

UPDATED: May 11, 2023 SMM ENCLOSED FOR MEDICAL PPO, HDHP, HDHP BASIC

what's not changing

Chevron added a variety of COVID-related coverage under medical and prescription drug coverage. The services below are already an ongoing part of your plan's coverage and will continue, unchanged, even though the Public Health Emergency has ended.

COVID-19 treatment

Covered charges related to medical care services and items purchased for **COVID-19 treatment.**

Applies to:

- Medical PPO
- HDHP
- HDHP Basic

COVID-19 immunizations (from a pharmacy)

Coverage for qualifying preventive care services, including immunizations like the COVID-19 vaccine, when received from a **pharmacy.**

Applies to:

- Prescription Drug Program

Online visits

Extended coverage for medical Online Visits includes visits from a LiveHealth Online provider *and* visits from a **non-LiveHealth Online provider.**

Applies to:

- Medical PPO
- HDHP
- HDHP Basic

May 11, 2023 UPDATED SMMs - MEDICAL, HDHP, HDHP BASIC FOR:

COVID-19 diagnostic testing when it is considered medically necessary and is ordered by a health care provider or physician.

COVID-19 coverage

medical PPO plan

effective march 27, 2020

update published as of may 11, 2023

Update to the summary plan descriptions (SPD)
All changes described in this SMM are effective March 27, 2020 unless otherwise indicated.

The enclosed information serves as an official summary of material modification (SMM) for the **Medical PPO Plan**. 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 **hr2.chevron.com/retiree** or by calling the HR Service Center at **1-888-825-5247**.

The Medical PPO Plan has been amended as required by the Families First Coronavirus Response Act (FFCRA) effective March 18, 2020 *and* the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) effective March 27, 2020. **This March 27, 2020 SMM contains the current plan provisions as a result of FFCRA and the CARES Act and a new, temporary extension of online visit services. It also includes an administrative clarification published as of January 1, 2022, regarding medical necessity for COVID-19 testing covered charges, and an update as of May 11, 2023, regarding the end of the Coronavirus Public Health Emergency.**

COVID-19 testing

Effective **March 18, 2020** the following temporary plan rules apply under the Medical PPO Plan:

- The **network or out-of-network annual deductible** does not apply to covered charges related to medical care services and items purchased for COVID-19 testing as required by the Families First Coronavirus Response Act and the Coronavirus Aid, Relief, and Economic Security Act. As a reminder, the Medical PPO Plan has separate deductibles, one for *medical services* and the other for *prescription drug* costs. The coverage for COVID-19 testing only applies to the deductible for covered **medical** services.

- The Medical PPO Plan will pay **100%** of the provider's **contracted rate** for covered charges for medical care services and items related to the furnishing or administration of COVID-19 testing, or evaluation for purposes of determining the need for such testing, when you see a **network provider**.

- When you see an **out-of-network** provider for covered charges for medical care services and items related to the furnishing or administration of COVID-19 testing, or evaluation for purposes of determining the need for such testing, the Medical PPO Plan will pay **100%** of the cash price as listed by the out-of-network provider on a public Internet website, *or alternatively*, a lower price the Medical PPO Plan claims administrator negotiates for covered charges.

- In accordance with existing plan rules and federal law, except for preventive care, the Medical PPO Plan does not provide coverage for charges, services or supplies that aren't **medically necessary**. For purposes of COVID-19 testing, this means that the plan coverage described here applies to individualized diagnosis or treatment of COVID-19 or another health condition 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).

This temporary plan rule for COVID-19 testing will be in effect beginning on **March 18, 2020** until the end of the Coronavirus Public Health Emergency (also known as the COVID-19 emergency period) on **May 11, 2023**.

After the end of the COVID-19 emergency period, these tests continue to be a covered service under **Anthem**, but starting **May 12, 2023**, coverage will follow *normal* plan rules for diagnostic and laboratory testing. This means your test may be subject to the deductible and/or coinsurance, depending on the situation. If you have questions about coverage, call Anthem.

COVID-19 treatment

The following rules apply to treatment under the Medical PPO Plan:

- Covered charges related to medical care services and items purchased for COVID-19 treatment will be subject to the applicable **network** or **out-of-network annual deductible** for covered **medical** services.
- After meeting the applicable network or out-of-network annual deductible, the Medical PPO Plan will pay:
  - **80%** of the provider's **contracted rate** for covered charges relating to medical care services and items purchased for COVID-19 treatment when you see a **network provider**.
  - **60%** of the provider's **billed charges** for covered charges relating to medical care services and items purchased for COVID-19 treatment when you see an **out-of-network provider**.

COVID-19 preventive service

The Medical PPO Plan currently provides coverage for preventive care services as required by the Patient Protection and Affordable Care Act and in accordance with guidelines based on recommendations from nationally recognized organizations, such as the U.S. Preventive Services Task Force. Effective **March 27, 2020** the Medical PPO Plan includes the following new rule for qualifying coronavirus preventive services:

- Any **qualifying coronavirus preventive service** will be considered eligible under existing preventive care coverage rules 15 business days after being designated as such.
- A qualifying coronavirus preventive service means an item, service or immunization that is intended to prevent or mitigate coronavirus disease 2019 and that is *either one* of the following:
  - An evidence-based item or service that has in effect a rating of *A* or *B* in the current recommendations of the United States Preventive Services Task Force.
  - An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

This updated publication notes that as of **December 11, 2020**, qualifying coronavirus preventive services are now available and included under the Medical PPO Plan's preventive care coverage. You can read more about the plan rules for this coverage in these SMMs:

- Medical Coverage: COVID-19 Preventive Services and Immunization Update (December 11, 2020)
- Prescription Drug Coverage: Coverage for Immunizations (February 15, 2021)

online visits

As previously communicated, member cost sharing for LiveHealth Online visits will be waived for Medical PPO participants from March 19, 2020 through June 17, 2020. Anthem provides access to online visits through the LiveHealth Online service for participants of the Medical PPO Plan. **LiveHealth Online** is a safe and effective way for you to receive medical guidance, including guidance for COVID-19, from your home using a smartphone, tablet or computer with a web cam. You're encouraged to use this service when possible to help prevent the spread of infection and improve access to care.

Online visits temporarily extended to include non-LiveHealth Online providers

Online visits are not covered outside of the LiveHealth Online provider group. However, in recognition of current physical distancing requirements during the COVID-19 pandemic, effective **March 18, 2020** the following temporary rules apply to **online visits** under the **Medical PPO Plan**:

- The Medical PPO Plan coverage rules for Online Visits will be extended to include covered charges for online visits from a **non-LiveHealth Online provider.**
- **Covered Charges** include medical consultations via telephone or using your network or out-of-network provider's virtual platform with a smartphone, tablet or computer with a webcam, where state laws allow.
- This temporary extension for online visits from a **non-LiveHealth Online provider** will be in effect beginning on **March 18, 2020** until the end of the COVID-19 emergency period.
- Online Visits from a **non-LiveHealth Online provider** will follow the Medical PPO Plan rules for **Office Visits**, as follows:
  - **Network** 100% of contracted rates after a $25 copayment if a primary care physician, no deductible *or* after a $40 copayment if a specialist, no deductible.
  - **Out-of-Network** 60% of the maximum allowed amount after deductible.

This updated publication notes that as of **January 1, 2021**, Chevron has decided this coverage is no longer temporary and coverage for non-LiveHealth Online providers will continue. You can read more about the plan rules for this coverage in this SMM:

- Online Visits under the Medical PPO Plan (January 1, 2021)

COVID-19 coverage

high deductible health plan (HDHP)

effective march 27, 2020

update published as of may 11, 2023

Update to the summary plan descriptions (SPD)
All changes described in this SMM are effective March 27, 2020 unless otherwise indicated.

The enclosed information serves as an official summary of material modification (SMM) for the **High Deductible Health Plan (HDHP)**. 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 **hr2.chevron.com/retiree** or by calling the HR Service Center at **1-888-825-5247**.

The High Deductible Health Plan (HDHP) has been amended as required by the Families First Coronavirus Response Act (FFCRA) effective March 18, 2020 *and* the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) effective March 27, 2020. **This March 27, 2020 SMM contains the current plan provisions as a result of FFCRA and the CARES Act and a new, temporary extension of online visit services. It also includes an administrative clarification published as of January 1, 2022, regarding medical necessity for COVID-19 testing covered charges, and an update as of May 11, 2023 regarding the end of the Coronavirus Public Health Emergency.**

COVID-19 testing

Effective **March 18, 2020** the following temporary plan rules apply under the HDHP:

- The **network or out-of-network annual combined deductible** does not apply to covered charges related to medical care services and items purchased for COVID-19 testing as required by the Families First Coronavirus Response Act and the Coronavirus Aid, Relief, and Economic Security Act. As a reminder, the HDHP has one combined deductible for medical, prescription drugs (both retail and mail-order), mental health and substance use disorder services.

- The HDHP will pay **100%** of the provider's **contracted rate** for covered charges for medical care services and items related to the furnishing or administration of COVID-19 testing, or evaluation for purposes of determining the need for such testing, when you see a **network provider**.

- When you see an **out-of-network** provider for covered charges for medical care services and items related to the furnishing or administration of COVID-19 testing, or evaluation for purposes of determining the need for such testing, the HDHP will pay **100%** of the cash price as listed by the out-of-network provider on a public Internet website, *or alternatively*, a lower price the HDHP claims administrator negotiates for covered charges.

- In accordance with existing plan rules and federal law, except for preventive care, the HDHP does not provide coverage for charges, services or supplies that aren't **medically necessary**. For purposes of COVID-19 testing, this means that the plan coverage described here applies to individualized diagnosis or treatment of COVID-19 or another health condition 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).

This temporary plan rule for COVID-19 testing will be in effect beginning on **March 18, 2020** until the end of the Coronavirus Public Health Emergency (also known as the COVID-19 emergency period) on **May 11, 2023**.

After the end of the COVID-19 emergency period, these tests continue to be a covered service under **Anthem**, but starting **May 12, 2023**, coverage will follow *normal* plan rules for diagnostic and laboratory testing. This means your test may be subject to the deductible and/or coinsurance, depending on the situation. If you have questions about coverage, call Anthem.

COVID-19 treatment

The following rules apply to treatment under the HDHP:

- Covered charges related to medical care services and items purchased for COVID-19 treatment will be subject to the **annual combined deductible**.
- After meeting the applicable network or out-of-network annual combined deductible, the HDHP will pay:
  - **80%** of the provider's **contracted rate** for covered charges relating to medical care services and items purchased for COVID-19 treatment when you see a **network provider**.
  - **60%** of the provider's **billed charges** for covered charges relating to medical care services and items purchased for COVID-19 treatment when you see an **out-of-network provider**.

COVID-19 preventive service

The HDHP currently provides coverage for preventive care services as required by the Patient Protection and Affordable Care Act and in accordance with guidelines based on recommendations from nationally recognized organizations, such as the U.S. Preventive Services Task Force. Effective **March 27, 2020** the HDHP includes the following new rule for qualifying coronavirus preventive services:

- Any **qualifying coronavirus preventive service** will be considered eligible under existing preventive care coverage rules 15 business days after being designated as such.
- A qualifying coronavirus preventive service means an item, service or immunization that is intended to prevent or mitigate coronavirus disease 2019 and that is *either one* of the following:
  - An evidence-based item or service that has in effect a rating of *A* or *B* in the current recommendations of the United States Preventive Services Task Force.
  - An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

This updated publication notes that as of December 11, 2020, qualifying coronavirus preventive services are now available and included under the HDHP preventive care coverage. You can read more about the plan rules for this coverage in these SMMs:

- Medical Coverage: COVID-19 Preventive Services and Immunization Update (December 11, 2020)
- Prescription Drug Coverage: Coverage for Immunizations (February 15, 2021)

online visits

Member cost sharing for LiveHealth Online visits will be waived for HDHP participants from March 19, 2020 through June 17, 2020. Anthem provides access to online visits through the LiveHealth Online service for participants of the HDHP. **LiveHealth Online** is a safe and effective way for you to receive medical guidance, including guidance for COVID-19, from your home using a smartphone, tablet or computer with a web cam. You're encouraged to use this service when possible to help prevent the spread of infection and improve access to care.

Online visits temporarily extended to include non-LiveHealth Online providers

Online visits are not covered outside of the LiveHealth Online provider group. However, in recognition of current physical distancing requirements during the COVID-19 pandemic, effective **March 18, 2020** the following temporary rules apply to **online visits** under the **HDHP**:

- The HDHP coverage rules for Online Visits will be extended to include covered charges for online visits from a **non-LiveHealth Online provider.**
- **Covered Charges** include medical consultations via telephone or using your network or out-of-network provider's virtual platform with a smartphone, tablet or computer with a webcam, where state laws allow.
- This temporary extension for online visits from a **non-LiveHealth Online provider** will be in effect beginning on **March 18, 2020** until the end of the COVID-19 emergency period.
- Online Visits from a **non-LiveHealth Online provider** will follow the HDHP rules for **Office Visits**, as follows:
  - **Network** 80% of contracted rates after deductible.
  - **Out-of-Network** 60% of the maximum allowed amount after deductible.

This updated publication notes that as of **January 1, 2021**, Chevron has decided this coverage is no longer temporary and coverage for non-LiveHealth Online providers will continue. You can read more about the plan rules for this coverage in this SMM:

- Online Visits under the HDHP (January 1, 2021)

COVID-19 coverage

high deductible health plan basic (HDHP Basic)
effective march 27, 2020

update published as of may 11, 2023

Update to the summary plan descriptions (SPD)
All changes described in this SMM are effective March 27, 2020 unless otherwise indicated.

The enclosed information serves as an official summary of material modification (SMM) for the **High Deductible Health Plan Basic (HDHP Basic)**. 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 **hr2.chevron.com/retiree** or by calling the HR Service Center at **1-888-825-5247**.

The High Deductible Health Plan Basic (HDHP Basic) has been amended as required by the Families First Coronavirus Response Act (FFCRA) effective March 18, 2020 *and* the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) effective March 27, 2020. **This March 27, 2020 SMM contains the current plan provisions as a result of FFCRA and the CARES Act and a new, temporary extension of online visit services. It also includes an administrative clarification published as of January 1, 2022, regarding medical necessity for COVID-19 testing covered charges, and an update as of May 11, 2023 regarding the end of the Coronavirus Public Health Emergency.**

COVID-19 testing

Effective **March 18, 2020** the following temporary plan rules apply under the HDHP Basic:

- The **network or out-of-network annual combined deductible** does not apply to covered charges related to medical care services and items purchased for COVID-19 testing as required by the Families First Coronavirus Response Act and the Coronavirus Aid, Relief, and Economic Security Act. As a reminder, the HDHP Basic has one combined deductible for medical, prescription drugs (both retail and mail-order), mental health and substance use disorder services.

- The HDHP Basic will pay **100%** of the provider's **contracted rate** for covered charges for medical care services and items related to the furnishing or administration of COVID-19 testing, or evaluation for purposes of determining the need for such testing, when you see a **network provider**.

- When you see an **out-of-network** provider for covered charges for medical care services and items related to the furnishing or administration of COVID-19 testing, or evaluation for purposes of determining the need for such testing, the HDHP Basic will pay **100%** of the cash price as listed by the out-of-network provider on a public Internet website, *or alternatively*, a lower price the HDHP Basic claims administrator negotiates for covered charges.

- In accordance with existing plan rules and federal law, except for preventive care, the HDHP Basic does not provide coverage for charges, services or supplies that aren't **medically necessary**. For purposes of COVID-19 testing, this means that the plan coverage described here applies to individualized diagnosis or treatment of COVID-19 or another health condition 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).

This temporary plan rule for COVID-19 testing will be in effect beginning on **March 18, 2020** until the end of the Coronavirus Public Health Emergency (also known as the COVID-19 emergency period) on **May 11, 2023**.

After the end of the COVID-19 emergency period, these tests continue to be a covered service under **Anthem**, but starting **May 12, 2023**, coverage will follow *normal* plan rules for diagnostic and laboratory testing. This means your test may be subject to the deductible and/or coinsurance, depending on the situation. If you have questions about coverage, call Anthem.

COVID-19 treatment

The following rules apply to treatment under the HDHP Basic:

- Covered charges related to medical care services and items purchased for COVID-19 treatment will be subject to the **annual combined deductible**.
- After meeting the applicable network or out-of-network annual combined deductible, the HDHP Basic will pay:
  - **70%** of the provider's **contracted rate** for covered charges relating to medical care services and items purchased for COVID-19 treatment when you see a **network provider**.
  - **50%** of the provider's **billed charges** for covered charges relating to medical care services and items purchased for COVID-19 treatment when you see an **out-of-network provider**.

COVID-19 preventive service

The HDHP Basic currently provides coverage for preventive care services as required by the Patient Protection and Affordable Care Act and in accordance with guidelines based on recommendations from nationally recognized organizations, such as the U.S. Preventive Services Task Force. Effective **March 27, 2020** the HDHP Basic includes the following new rule for qualifying coronavirus preventive services:

- Any **qualifying coronavirus preventive service** will be considered eligible under existing preventive care coverage rules 15 business days after being designated as such.
- A qualifying coronavirus preventive service means an item, service or immunization that is intended to prevent or mitigate coronavirus disease 2019 and that is *either one* of the following:
  - An evidence-based item or service that has in effect a rating of *A* or *B* in the current recommendations of the United States Preventive Services Task Force.
  - An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

This updated publication notes that as of December 11, 2020, qualifying coronavirus preventive services are now available and included under the HDHP Basic preventive care coverage. You can read more about the plan rules for this coverage in these SMMs:

- Medical Coverage: COVID-19 Preventive Services and Immunization Update (December 11, 2020)
- Prescription Drug Coverage: Coverage for Immunizations (February 15, 2021)

online visits

Member cost sharing for LiveHealth Online visits will be waived for HDHP Basic participants from March 19, 2020 through June 17, 2020. Anthem provides access to online visits through the LiveHealth Online service for participants of the HDHP Basic. **LiveHealth Online** is a safe and effective way for you to receive medical guidance, including guidance for COVID-19, from your home using a smartphone, tablet or computer with a web cam. You're encouraged to use this service when possible to help prevent the spread of infection and improve access to care.

Online visits temporarily extended to include non-LiveHealth Online providers

Online visits are not covered outside of the LiveHealth Online provider group. However, in recognition of current physical distancing requirements during the COVID-19 pandemic, effective **March 18, 2020** the following temporary rules apply to **online visits** under the **HDHP Basic**:

- The HDHP Basic coverage rules for Online Visits will be extended to include covered charges for online visits from a **non-LiveHealth Online provider.**
- **Covered Charges** include medical consultations via telephone or using your network or out-of-network provider's virtual platform with a smartphone, tablet or computer with a webcam, where state laws allow.
- This temporary extension for online visits from a **non-LiveHealth Online provider** will be in effect beginning on **March 18, 2020** until the end of the COVID-19 emergency period. (As of the date of this updated publication, the emergency period ends January 16, 2022, but is subject to change.)
- Online Visits from a **non-LiveHealth Online provider** will follow the HDHP Basic rules for **Office Visits**, as follows:
  - **Network** 70% of contracted rates after deductible.
  - **Out-of-Network** 50% of the maximum allowed amount after deductible.

This updated publication notes that as of **January 1, 2021**, Chevron has decided this coverage is no longer temporary and coverage for non-LiveHealth Online providers will continue. You can read more about the plan rules for this coverage in this SMM:

- Online Visits under the HDHP Basic (January 1, 2021)

contact

Contact **Anthem** directly at **1-844-627-1632** to discuss 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.**

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. 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. Unless required by applicable law, there are no vested rights with respect to any Chevron health and welfare plan benefit or to any company contributions towards the cost of such health and welfare plan benefits. Some benefit plans and policies described in this document may be subject to collective bargaining and, therefore, may not apply to union-represented employees.

May 11 – December 31, 2023 UPDATED SMM –
PRESCRIPTION DRUG PROGRAM FOR:

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.

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

prescription drug program

effective january 15, 2022

update published as of may 11, 2023

Update to the summary plan description (SPD)
All changes described in this SMM are effective January 15, 2022.

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.).

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

When you enroll in the Medical PPO Plan, the High Deductible Health Plan (HDHP) or the High Deductible Health Plan Basic (HDHP Basic), you are also automatically enrolled in prescription drug coverage through the Prescription Drug Program with Express Scripts. This change applies to the Prescription Drug Program for participants in the Medical PPO Plan, the High Deductible Health Plan (HDHP) and the High Deductible Health Plan Basic (HDHP Basic).

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.

[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.

- **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.

- 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).

This temporary plan rule for at-home COVID-19 diagnostic tests has been extended to continue beyond the end of the Coronavirus Public Health Emergency on May 11, 2023 and will instead expire on **December 31, 2023**.

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

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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.

(Continued next page.)

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**

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May 11, 2023 UPDATED SMMs - MEDICAL, HDHP, HDHP BASIC FOR:

COVID-19 immunizations (received from your provider or a health care facility)

Your plans provide coverage for qualifying preventive care services, including immunizations like the COVID-19 vaccine under **Anthem**. Starting **May 12, 2023**, COVID-19 immunizations will follow *normal* plan rules for preventive care services. This means your immunization is still free from a network provider, but subject to the deductible and/or coinsurance when you visit an out-of-network provider.

COVID-19 immunization coverage updates

medical PPO plan

effective december 11, 2020

update published as of may 11, 2023

Update to the summary plan descriptions (SPD)
All changes described in this SMM are effective December 11, 2020 unless otherwise indicated.

The enclosed information serves as an official summary of material modification (SMM) for the **Medical PPO Plan**. 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 **hr2.chevron.com/retiree** or by calling the HR Service Center at **1-888-825-5247**.

COVID-19 preventive service and immunization update

The Medical PPO Plan currently provides coverage for preventive care services as required by the Patient Protection and Affordable Care Act and in accordance with guidelines based on recommendations from nationally recognized organizations, such as the U.S. Preventive Services Task Force. As previously communicated, effective March 27, 2020 the Medical PPO Plan was updated to include coverage for qualifying coronavirus preventive services as part of the plan's existing preventive care coverage rules, when such services became available. **As of December 11, 2020, qualifying coronavirus preventive services are now available and included under the Medical PPO Plan's preventive care coverage.**

What's a qualifying coronavirus preventive service?

A qualifying coronavirus preventive service means an item, service or immunization that is intended to prevent or mitigate coronavirus disease 2019 and that is *either one* of the following:

- An **immunization** that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
- An **evidence-based item or service** that has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.

Temporary extension of coverage for out-of-network COVID-19 immunizations

As required by the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), effective **December 11, 2020** the following *temporary* rules apply to **qualifying coronavirus preventive services** under the **Medical PPO Plan**:

- When you see a **network provider**, the Medical PPO Plan will pay **100 percent** of the provider's **contracted rate** with no copayment, coinsurance or deductible for covered charges related to qualifying coronavirus preventive services.
- When you see an **out-of-network provider**, the **out-of-network deductible *will not* apply**, and the Medical PPO Plan will pay covered charges in an amount that is reasonable in comparison to prevailing market rates (or an alternative lower price, if negotiated) for qualifying coronavirus preventive services. Reasonable amounts are determined by Anthem, the claims administrator.

These temporary rules for qualifying coronavirus preventive services will be in effect beginning on **December 11, 2020** until the end of the Coronavirus Public Health Emergency (also known as the COVID-19 emergency period) on **May 11, 2023**.

A reminder about normal preventive care coverage rules

Starting May 12, 2023, all of the normal Medical PPO Plan rules for preventive care shall apply to qualifying coronavirus preventive services. As a reminder, normal Medical PPO Plan preventive care rules are as follows:

- When you see a **network provider**, the Medical PPO Plan will pay **100 percent** of the provider's contracted rate with no copayment, coinsurance or deductible for covered charges related to preventive care services.
- When you see an **out-of-network provider**, the Medical PPO Plan will pay **60 percent** of the maximum allowed amount for covered charges related to preventive care services, and the annual **out-of-network medical deductible *will* apply**.

contact

Contact **Anthem** directly at **1-844-627-1632** to discuss 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.**

COVID-19 immunization coverage updates

high deductible health plan (HDHP)

effective december 11, 2020

update published as of may 11, 2023

Update to the summary plan descriptions (SPD)
All changes described in this SMM are effective December 11, 2020 unless otherwise indicated.

The enclosed information serves as an official summary of material modification (SMM) for the **High Deductible Health Plan (HDHP)**. 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 **hr2.chevron.com/retiree** or by calling the HR Service Center at **1-888-825-5247**.

COVID-19 preventive service and immunization update

The High Deductible Health Plan (HDHP) currently provides coverage for preventive care services as required by the Patient Protection and Affordable Care Act and in accordance with guidelines based on recommendations from nationally recognized organizations, such as the U.S. Preventive Services Task Force. As previously communicated, effective March 27, 2020 the HDHP was updated to include coverage for qualifying coronavirus preventive services as part of the plan's existing preventive care coverage rules, when such services became available. **As of December 11, 2020, qualifying coronavirus preventive services are now available and included under the HDHP's preventive care coverage.**

What's a qualifying coronavirus preventive service?

A qualifying coronavirus preventive service means an item, service or immunization that is intended to prevent or mitigate coronavirus disease 2019 and that is *either one* of the following:

- An **immunization** that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
- An **evidence-based item or service** that has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.

Temporary extension of coverage for out-of-network COVID-19 immunizations

As required by the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), effective **December 11, 2020** the following *temporary* rules apply to **qualifying coronavirus preventive services** under the **High Deductible Health Plan**:

- When you see a **network provider**, the High Deductible Health Plan will pay **100 percent** of the provider's **contracted rate** with no copayment, coinsurance or deductible for covered charges related to qualifying coronavirus preventive services.
- When you see an **out-of-network provider**, the **out-of-network combined deductible *will not* apply**, and the High Deductible Health Plan will pay covered charges in an amount that is reasonable in comparison to prevailing market rates (or an alternative lower price, if negotiated) for qualifying coronavirus preventive services. Reasonable amounts are determined by Anthem, the claims administrator.

These temporary rules for qualifying coronavirus preventive services will be in effect beginning on **December 11, 2020** until the end of the Coronavirus Public Health Emergency (also known as the COVID-19 emergency period) on **May 11, 2023**.

A reminder about normal preventive care coverage rules

Starting May 12, 2023, all of the normal High Deductible Health Plan rules for preventive care shall apply to qualifying coronavirus preventive services. As a reminder, normal High Deductible Health Plan preventive care rules are as follows:

- When you see a **network provider**, the High Deductible Health Plan will pay **100 percent** of the provider's contracted rate with no copayment, coinsurance or deductible for covered charges related to preventive care services.
- When you see an **out-of-network provider**, the High Deductible Health Plan will pay **60 percent** of the maximum allowed amount for covered charges related to preventive care services, and the annual **out-of-network combined deductible *will* apply**.

contact

Contact **Anthem** directly at **1-844-627-1632** to discuss 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.**

COVID-19 immunization coverage updates

high deductible health plan basic (HDHP Basic)

effective december 11, 2020

update published as of may 11, 2023

Update to the summary plan descriptions (SPD)
All changes described in this SMM are effective December 11, 2020 unless otherwise indicated.

The enclosed information serves as an official summary of material modification (SMM) for the **High Deductible Health Plan Basic (HDHP Basic)**. 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 **hr2.chevron.com/retiree** or by calling the HR Service Center at **1-888-825-5247**.

COVID-19 preventive service and immunization update

The High Deductible Health Plan Basic (HDHP Basic) currently provides coverage for preventive care services as required by the Patient Protection and Affordable Care Act and in accordance with guidelines based on recommendations from nationally recognized organizations, such as the U.S. Preventive Services Task Force. As previously communicated, effective March 27, 2020 the HDHP Basic was updated to include coverage for qualifying coronavirus preventive services as part of the plan's existing preventive care coverage rules, when such services became available. **As of December 11, 2020, qualifying coronavirus preventive services are now available and included under the HDHP Basic's preventive care coverage.**

What's a qualifying coronavirus preventive service?

A qualifying coronavirus preventive service means an item, service or immunization that is intended to prevent or mitigate coronavirus disease 2019 and that is *either one* of the following:

- An **immunization** that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
- An **evidence-based item or service** that has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.

Temporary extension of coverage for out-of-network COVID-19 immunizations

As required by the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), effective **December 11, 2020** the following *temporary* rules apply to **qualifying coronavirus preventive services** under the **High Deductible Health Plan Basic**:

- When you see a **network provider**, the High Deductible Health Plan Basic will pay **100 percent** of the provider's **contracted rate** with no copayment, coinsurance or deductible for covered charges related to qualifying coronavirus preventive services.
- When you see an **out-of-network provider**, the **out-of-network combined deductible *will not* apply**, and the High Deductible Health Plan Basic will pay covered charges in an amount that is reasonable in comparison to prevailing market rates (or an alternative lower price, if negotiated) for qualifying coronavirus preventive services. Reasonable amounts are determined by Anthem, the claims administrator.

These temporary rules for qualifying coronavirus preventive services will be in effect beginning on **December 11, 2020** until the end of the Coronavirus Public Health Emergency (also known as the COVID-19 emergency period) on **May 11, 2023**.

A reminder about normal preventive care coverage rules

Starting May 12, 2023, all of the normal High Deductible Health Plan Basic rules for preventive care shall apply to qualifying coronavirus preventive services. As a reminder, normal High Deductible Health Plan Basic preventive care rules are as follows:

- When you see a **network provider**, the High Deductible Health Plan Basic will pay **100 percent** of the provider's contracted rate with no copayment, coinsurance or deductible for covered charges related to preventive care services.
- When you see an **out-of-network provider**, the High Deductible Health Plan Basic will pay **50 percent** of the maximum allowed amount for covered charges related to preventive care services, and the annual **out-of-network combined deductible *will* apply**.

contact

Contact **Anthem** directly at **1-844-627-1632** to discuss 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.**

annual health benefit notices

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

Access a copy of the notices referenced here at any time from the **Legal Notices** section on **hr2.chevron.com**

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

The *Notice Regarding Wellness Program* 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.

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