chevron benefit plan changes

effective january 1, 2025

(unless otherwise indicated)
for COBRA participants

sign up for electronic delivery

Sign up for electronic delivery of your Chevron COBRA benefit information at any time from the **BenefitConnect | COBRA** 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 is here

It's time to make open enrollment elections for your 2024 Chevron COBRA coverage. **Open enrollment is November 5 through November 19, 2024.** Any elections you make for your COBRA coverage during open enrollment become effective January 1, 2025. This newsletter provides information about changes to your COBRA benefits and how to enroll.

Be sure to learn about the changes coming to your 2025 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, **2025 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 2025 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 2025 premium payments.

how to enroll
november 5 through november 19, 2024

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 19, 2024**.

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 **11:59 p.m. Pacific time** on **November 19, 2024**.

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 2025 for 2026 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 5** through **November 19, 2024**, become effective January 1, 2025.

you must act
november 5 - november 19, 2024 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 2025 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 2025, 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**.

2025 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:

2025 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)

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.

annual combined deductible

high deductible health plan (HDHP)

effective january 1, 2025

Update to the summary plan description (SPD)
All changes described in this SMM are effective January 1, 2025.

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 **hr2.chevron.com/retiree**) or by calling the HR Service Center at **1-888-825-5247**.

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, 2025**, 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 Dependent Adult Only*	$3,300	$6,600
You + One Adult†	$6,600	$13,200
You + Child(ren) † Dependent Child(ren) Only*†	$6,600	$13,200
You + Family† Dependent Adult + Child(ren)* †	$6,600	$13,200

** Coverage tier available only under pre-65 retiree health coverage.*

† When you cover yourself and one or more dependents under family coverage, the whole family has shared deductibles as indicated in the chart above. Each covered family member also has individual or embedded medical deductibles (You Only/Dependent Adult Only) that counts toward the family medical deductible.

annual combined deductible

mental health and substance use disorder plan

effective january 1, 2025

Update to the summary plan descriptions (SPD)
All changes described in this SMM are effective January 1, 2025 unless otherwise indicated.

The enclosed information serves as an official summary of material modification (SMM) for the plans referenced herein. Please keep this information with your other plan documents for future reference. You can access the summary plan descriptions for your benefits at **hr2.chevron.com** (or **hr2.chevron.com/retiree**) or by calling the HR Service Center at **1-888-825-5247**.

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, 2025**, 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 Dependent Adult Only*	$3,300
You + One Adult†	$6,600
You + Child(ren) † Dependent Child(ren) Only*†	$6,600
You + Family† Dependent Adult + Child(ren)* †	$6,600

** Coverage tier available only under pre-65 retiree health coverage.*

† When you cover yourself and one or more dependents under family coverage, the whole family has a shared deductible as indicated in the chart above. Each covered family member also has an individual or embedded medical deductible (You Only/Dependent Adult Only) that counts toward the family medical deductible.

(continued next page)

worksite biometric screenings

company-sponsored medical plans

update september 2024

Update to the summary plan description (SPD)

The enclosed information serves as an official summary of material modification (SMM) for **all company-sponsored medical plans**. 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**.

worksite biometric screenings

Starting in 2024, onsite (worksite) biometric screenings may be periodically available at select Chevron work locations to active employees enrolled in a Chevron-sponsored U.S. medical plan. You can get your numbers and a confidential review of your results with a health professional at these events, free of charge, as part of an enhancement of the wellness offerings under your Chevron medical benefit coverage. If a screening event becomes available at your worksite, you will be notified and provided with additional information about how to register for the event.

new coverage requirements for GLP-1 medications

chevron prescription drug program

effective january 1, 2025

Update to the summary plan descriptions (SPD)
Changes described in this SMM are effective January 1, 2025.

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**.

new coverage requirements for GLP-1 medications

The Chevron Prescription Drug Program already provides coverage for GLP-1 medications, used for both diabetes and weight loss. Effective **January 1, 2025**, these medications will be subject to new coverage requirements, as outlined below. **Your action may be required (see page 2).**

GLP-1 for weight loss requirements

These medications require prior authorization and are managed through Express Script's condition-specific programs, EncircleRx, the Diabetes Care Value Program℠ and the Weight Management Care Value℠ Program. To receive coverage for weight-loss purposes, you must meet *new* BMI or other clinical requirements, enroll and engage in the Omada virtual health program, and your doctor must provide documentation during the prior authorization process. Here's how it works:

- **For initial prior authorization, you must meet *all* the following requirements:**
  - You must meet BMI requirements as established by Express Scripts.
  - You must also enroll in the Express Script's Diabetes Prevention Program, currently administered by Omada Health. Omada can help you create healthier habits to achieve long-lasting results.
- **For refills:** To be eligible for each refill, you must satisfy **all** the following Diabetes Prevention Program engagement requirements:
  - Use the Omada mobile app at least four times each month* by completing lessons, recording meals and/or exercise, engaging with an Omada health coach, or engaging with your peer group or online community.
  - Weigh in at least four times each month* using the smart scale provided by Omada Health.
- **Upon your *first* prescription renewal:** Prior authorization renewal will be required. You must have achieved a targeted decrease in body weight of 5%. Prior authorization renewal will be denied if you have not achieved the target decrease percentage, but your doctor can appeal once you have achieved the required goal.

** For purposes of this requirement, a month is defined as the rolling 30 days prior to your next prescription fill.*

GLP-1 for diabetes management requirements

These medications for diabetes purposes are managed through Express Script's condition-specific programs, EncircleRx and the Diabetes Care Value Program℠. Your prescribing physician may be required to provide new information and proof of clinical diabetes during both initial prior authorization and the ongoing renewals, including: either an A1C lab value, a blood glucose test result or medical diagnosis code.

I am currently taking a GLP-1 medication. What do I need to do?

For diabetes management	No action is required of you. When your current medication is due for a renewal of prior authorization after January 1, 2025, your physician may be prompted to provide the additional required information.
For weight loss	All participants currently taking a GLP-1 medication for weight loss will be contacted in November 2024 to **restart the initial prior authorization process**, as outlined above, *regardless* of when your prior authorization renewal is due. – Your doctor will be prompted to **provide *initial* prior authorization** under the new requirements by January 1, 2025. – You will be required to **enroll** in the Express Scripts Diabetes Prevention Program with Omada Health by January 1, 2025. – You will be required to complete the **monthly Omada program engagement** requirements to receive your **refills**. If you have not completed the engagement requirements for the month, your refill will be denied until you complete your monthly goal. – You must meet the target 5% weight loss requirement upon your first prescription renewal.

about the express scripts diabetes prevention program

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

who to contact

If you have questions about these plan updates or the programs discussed here, contact **Express Scripts Member Services** at **1-800-987-8368** starting October 14, 2025.

new condition-specific programs

chevron prescription drug program

effective january 1, 2025

Update to the summary plan descriptions (SPD)
Changes described in this SMM are effective January 1, 2025.

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 program update

Weight Management Care Value℠ Program*

For your information, effective January 1, 2025, **Weight Management Care Value℠ Program**, a condition-specific program*, has been added to your Express Scrips prescription drug coverage. This program helps eligible participants achieve and maintain a healthy weight through a combination of formulary, utilization management and specialized and clinical support from the Express Scripts Therapeutic Resource Center®. Additional support may include participation in the Diabetes Prevention Program under the Express Scripts Diabetes Care Value Program℠, virtual medication consultations with primary care physicians from MDLIVE, or both. MDLive consultations are available for participants living with a BMI of 30+ or BMI of 27+ and comorbidities and include education, support, counseling, and training resources for taking their medication.

EncircleRx*

EncircleRx manages weight loss GLP-1 prescription drug costs by integrating digital health tools and enhanced prior authorization criteria to improve the appropriateness of overall utilization and health outcomes. The program leverages the Diabetes Prevention Program under the Express Scripts Diabetes Care Value Program℠ to provide personalized support to eligible participants.

If you have questions about these or other condition-specific programs, contact **Express Scripts Member Services** at **1-800-987-8368** starting October 14, 2025.

** **What is a condition-specific 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 services and support tools that are specific to certain health conditions. These are referred to as condition-specific programs. 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.*

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.

540 S. Melrose Street
Placentia, CA 92870