# chevron benefit plan changes

## effective january 1, 2025
## (unless otherwise indicated)
## for active employee coverage

Open enrollment instructions and highlights of 2025 changes were previously sent to you under separate cover prior to the enrollment period. This publication is provided for your records and includes full details about the 2025 Chevron benefit plan changes. No action is required.

This information is also posted online at **hr2.chevron.com/OpenEnrollment**.

## next time, consider electronic delivery

Sign up to receive your Chevron benefit plan updates to an email of your choice. You'll receive your plan updates *earlier* than the post office can deliver, and you'll conserve resources. The same information here is *already* available online, from work or home, at **hr2.chevron.com/OpenEnrollment**.

## how to sign up electronic delivery

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

- Login to **hr2.chevron.com/BenefitConnect**
- Click on your **name** in the upper right corner.
- Choose **My Information** from the drop-down menu.
- Scroll to the bottom of the page and follow the instructions under **Communication Preference**.

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# 2025 chevron employee benefit changes

**Update to the summary plan descriptions (SPD)**

The enclosed **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)
- Health Care Flexible Spending Account (Health FSA)
- Dependent Care Flexible Spending Account (Dependent Care FSA)

## 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.**

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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, 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<br>Dependent Adult Only* | $3,300 | $6,600 |
| You + One Adult[†] | $6,600 | $13,200 |
| You + Child(ren)[†]<br>Dependent Child(ren) Only*[†] | $6,600 | $13,200 |
| You + Family[†]<br>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.*

# 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$^{SM}$ and the Weight Management Care Value$^{SM}$ 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.<br>– Your doctor will be prompted to **provide *initial* prior authorization** under the new requirements by January 1, 2025.<br>– You will be required to **enroll** in the Express Scripts Diabetes Prevention Program with Omada Health by January 1, 2025.<br>– 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.<br>– 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.

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# 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.*

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# one-time company contribution

## health care flexible spending account

## 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 **Health Care Flexible Spending Account (Health FSA)**. 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**.

## one-time company contribution

A one-time company contribution will be automatically added to Health Care Flexible Spending Account (Health FSA) accounts in 2025.

### Why is there a one-time company contribution?

Your contributions to a health flexible spending account, like Chevron's Health FSA, reduce your taxable income and are therefore subject to certain federal tax law requirements, including the **use it or lose it rule**. Under this rule, you forfeit any remaining balance left in your account after the annual claim filing deadline. These forfeited funds are used to cover certain expenses needed to operate the plan or for any purpose determined by Chevron, including for the benefit of plan participants.

We've determined that the Chevron Health FSA has a surplus of forfeited participant funds at this time and, in accordance with applicable law, will use it to help fund a one-time company contribution to participant FSA accounts. **This one-time company contribution will be automatically added to Chevron Health FSA accounts in 2025.** Chevron generally does not make any contributions to flexible spending accounts and there is no guarantee of any future contribution.

### How the one-time company contribution works

- You are eligible if you are an active employee enrolled in the Chevron Health FSA at any point between **January 1 and November 30, 2025**.
- The one-time company contribution is a flat amount of **$500.00** per enrolled employee.
- The one-time company contribution is **in addition to** the maximum amount you're allowed to contribute to the Chevron Health FSA in 2025. This one-time contribution is also not subject to the 2025 IRS maximum for health care flexible spending account contributions.
- The one-time company contribution **applies specifically to the Chevron Health FSA**.
- There are **no other changes to Chevron Health FSA rules**. Eligible expenses, maximum contribution limits, spending and claim deadlines, and the use it or lose it rule continue to apply according to the plan's standard rules.

## You must enroll to participate

If you want to participate in the Chevron Health FSA in 2025, **you must enroll**, even if you *already* participate in 2024. Coverage does not automatically carry over from year-to-year.

- If you enroll in the Chevron Health FSA during open enrollment – October 14 through October 25, 2024 – the company contribution will be automatically available in your account by the end of January 2025.
- If you enroll mid-year 2025 (and prior to December 1, 2025) due to new eligibility or other qualifying event, the company contribution will be automatically available in your account in conjunction with the next pay cycle after your 31-day enrollment period closes.

Remember, if you are enrolled in a high deductible health plan – including the Chevron High Deductible Health Plan (HDHP) or the High Deductible Health Plan Basic (HDHP Basic) – you are not allowed to participate in a **health care flexible spending account.** If you are enrolled in a high deductible health plan, you can save for health care costs with a **health savings account** instead. A health **savings account** is a bank account separate from your benefit plans and does not have a use it or lose it rule. Chevron currently contributes to your health savings account annually. Learn more.

## contact

- More **Chevron Health FSA** information and claim resources are available on hr2.chevron.com.
- Contact the **Chevron HR Service Center** at **1-888-825-5247** (1-832-854-5800 outside U.S.) starting October 14 if you have questions about the one-time company contribution.
- Contact **Anthem** directly at **1-844-627-1632** to discuss reimbursement claims, eligible expenses, or the Health FSA debit card.

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# annual contribution limit

## health care flexible spending account

## effective january 1, 2025

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The enclosed information serves as an official summary of material modification (SMM) for the **Health Care Flexible Spending Account (Health FSA)**. 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**.

## maximum annual contribution limit

This change applies to the Health Care Flexible Spending Account (Health FSA).

Effective **January 1, 2025** the maximum amount you're allowed to contribute to the Chevron Health FSA is increasing:

- You can contribute a minimum of **$120**.
- You can contribute up to **$3,200***.
- In 2025, Chevron will contribute a flat amount of **$500.00** per enrolled employee to the Health FSA. This special, one-time company contribution is **in addition to** the maximum amount you're allowed to contribute to the Chevron Health FSA. This one-time contribution is not subject to the 2025 IRS maximum for health care flexible spending account employee contributions.

* The IRS limits the amount employees can contribute to a flexible spending account, and the limit may change from year-to-year. You cannot contribute more than the IRS annual limit each year. However, employers, like Chevron, are permitted to set an annual limit for their plans that may be *less than* the IRS annual limit. Should the IRS announce an increase to the maximum limit for 2025, Chevron is unable to change the Health FSA 2025 maximum contribution limit to align with the new IRS limit. This is due to the timing of Chevron's open enrollment administrative activities.

## contact

- More **Chevron Health FSA** information and claim resources are available on hr2.chevron.com.
- Contact **Anthem** directly at **1-844-627-1632** to discuss reimbursement claims, eligible expenses, or the Health FSA debit card.

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# new name for chevron’s health care spending account plan

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 **Chevron Health Care Spending Account (HCSA) 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 by calling the HR Service Center at **1-888-825-5247**.

## new plan name

This change applies to the Health Care Spending Account (HCSA).

Effective **January 1, 2025** the HCSA plan name will change to the **Chevron Health Care Flexible Spending Account (Health FSA)**.

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# annual combined deductible

## mental health and substance use disorder plan

## effective january 1, 2025

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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, 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<br>Dependent Adult Only* | $3,300 |
| You + One Adult† | $6,600 |
| You + Child(ren) †<br>Dependent Child(ren) Only*† | $6,600 |
| You + Family†<br>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.*

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# 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**.

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## 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.

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# new benefit use requirements for global choice plan participants

## mental health and substance use disorder plan

## effective july 1, 2024

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

## new benefit use requirements

This change applies to Chevron Mental Health and Substance Use Disorder (MHSUD) Plan participants who are *also* enrolled in the Global Choice Plan (U.S.-Payroll Expatriates)

As a reminder, you are automatically enrolled in the **MHSUD Plan** for behavioral health coverage if you are an eligible **U.S.-payroll employee**. Your **dependents** are also enrolled in the MHSUD Plan if they are eligible for and enrolled in a medical plan to which Chevron contributes, like the Global Choice Plan.

**Your medical coverage under the Global Choice Plan now *also* includes access to behavioral health services. For this reason, effective July 1, 2024, *new* requirements for Global Choice participants apply when using behavioral health coverage under the MHSUD Plan, as follows:**

- You have the choice to use the behavioral health benefits provided by your medical coverage under the **Global Choice Plan**, *or* use the benefits provided under the **MHSUD Plan**. However, you cannot make a claim to both your Global Choice Plan *and* the MHSUD Plan for the *same* service. In addition,
- If you use the benefit provided by the **MHSUD**, there is no deductible for behavioral health services. If you use the benefit provided by your **medical coverage under the Global Choice Plan**, behavioral health services are subject to the Global Choice deductible. Contact your medical plan administrator *directly* for information about this benefit, including the deductible and additional plan rules that may apply.

*(continued next page)*

## contact

- Contact **Cigna** directly at **1-800-441-2668** (1-302-797-3100 outside the U.S.) for information about the behavioral health coverage provided by your Global Choice Plan.
- Contact **Carelon** directly at **1-800-847-2438** (714-763-2420 outside the U.S.) for more information about the behavioral health coverage provided by the MHSUD Plan.

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.

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# new name for chevron's dependent day care spending account plan

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 **Chevron Dependent Day Care Spending Account (DCSA) 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 by calling the HR Service Center at **1-888-825-5247**.

## new plan name

This change applies to the Dependent Day Care Spending Account (DCSA).

Effective **January 1, 2025** the DCSA plan name will change to the **Chevron Dependent Care Flexible Spending Account (Dependent Care FSA)**.

*This communication provides only certain highlights about changes of benefit provisions. It is not intended to be a complete explanation. If there are any discrepancies between this communication and the legal plan documents, the legal plan documents will prevail to the extent permitted by law. Oral statements about plan benefits are not binding on Chevron or the applicable plan. There are no vested rights with respect to Chevron health and welfare plans or any company contributions towards the cost of such health and welfare plans. Rather, Chevron Corporation reserves all rights, for any reason and at any time, to amend, change or terminate these plans or to change or eliminate the company contribution toward the cost of such plans. Such amendments, changes, terminations or eliminations may be applicable without regard to whether someone previously terminated employment with Chevron or previously was subject to a grandfathering provision. Some benefit plans and policies described in this document may be subject to collective bargaining and, therefore, may not apply to union-represented employees.*

# 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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