Global Choice Plan
(U.S.-Payroll Expatriates)
Summary Plan Description (SPD)
Effective January 1, 2014
This summary plan description (SPD) describes the Global Choice Plan (U.S.-Payroll Expatriates) as of January 1, 2014 sponsored by Chevron that is available to eligible U.S.-payroll expatriates and their eligible dependents.

This information constitutes the SPD of the Chevron Global Choice Plan (U.S.-Payroll Expatriates), as this plan applies to the U.S.-payroll expatriates as required by the Employee Retirement Income Security Act of 1974 (ERISA). If you are not a U.S.-payroll expatriate or an eligible dependent of a U.S.-payroll expatriate, then this SPD does not apply to you.

This description doesn’t cover every provision of the plan. Many complex concepts have been simplified or omitted to present more understandable plan descriptions. If these plan descriptions are incomplete or if there’s any inconsistency between the information provided here and the official plan texts, the provisions of the official plan texts will prevail.

Chevron Corporation reserves the right to change or terminate a plan at any time and for any reason. A change also can be made to premiums and future eligibility for coverage and can apply to those who retired in the past, as well as to those who retire in the future. Once approved, plan changes are incorporated into the plan texts, SPDs and vendor administration at the effective date.

If you enroll in the Global Choice Plan, your coverage automatically includes the following types of health coverage:

- Medical benefits obtained inside or outside the U.S. (Cigna).
- Prescription drugs obtained outside the U.S. (Cigna).
- Prescription drugs obtained inside the U.S. through the Chevron Prescription Drug Program (Express Scripts).
- Basic vision benefits through the Chevron Vision Program (VSP Vision Care).

For more information about other health benefits available to U.S.-payroll expatriates, such as dental mental health and substance abuse, or additional vision coverage, go to the U.S. Benefits website at hr2.chevron.com and review summary plan descriptions for those plans.
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update to addresses
for benefits correspondence
effective June 1, 2020

Update to the summary plan descriptions (SPD)
All changes described in this SMM are effective June 1, 2020.

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 by calling the HR Service Center at 1-888-825-5247 (1-832-854-5800 outside the U.S.).

The new address for correspondence with the Chevron Human Resources Service Center is as follows:

- For health and welfare correspondence
  Chevron Human Resources Service Center | PO Box 981901 | El Paso, TX 79998

- For pension and QDRO correspondence
  Chevron Human Resources Service Center | PO BOX 981909 | El Paso, TX 79998

- For COBRA correspondence
  Use the address included on your payment coupons

The addresses below may be referenced in this summary plan description and should be considered no longer active and valid. Please use the appropriate new address above in place of these addresses below:

- P.O. Box 18012
  Norfolk, VA 23501

- P.O. Box 199708
  Dallas, TX 75219-9708

- COBRA/Conduent HR Services
  P.O. Box 382064
  Pittsburgh, PA 15251-8064

- The QDRO Service Center
  1434 Crossways
  Chesapeake, VA 23320

- The QDRO Processing Group
  2828 N. Haskell Ave. Bldg 5
  Mail Stop 516
  Dallas, TX 75204-2909
Key Health Benefit Contacts

Human Resources (HR) Service Center
If you have questions regarding your plan options, eligibility and enrollment, please call the HR Service Center.

- 1-888-825-5247 (inside the U.S.)
- 610-669-8595 (outside the U.S.)

U.S. Benefits HR2 Website on the Internet
You can access the HR2 website on the Internet, from home or at work. You can access summary plan descriptions, other benefit information and links to other key benefit websites, such as Benefits Connection.

- hr2.chevron.com

U.S. HR Website on the Chevron Intranet
You can access the U.S. HR website only from the Chevron intranet. You can access HR information in addition to information about your benefits, such as summary plan descriptions and links to other key benefit websites, such as Benefits Connection and Vanguard.

- hr.chevron.com/northamerica/us/

Cigna
Global Choice Plan medical coverage (inside and outside the U.S.) and prescription drugs (obtained outside the U.S.).

- www.cignaenvoy.com
- Customer Service
  - Toll free: 1-800-828-5822
  - Direct (collect calls accepted): 001-302-797-3871
  - Toll-free facsimile number: 001-302-797-3150

- Mail Delivery
  Cigna
  P.O. Box 15050
  Wilmington, DE 19850-5050

- Courier Delivery
  Cigna
  300 Bellevue Parkway
  Wilmington, DE 19809
**Express Scripts**  
Global Choice Plan prescription drugs (obtained inside the U.S.).

- [www.Express-Scripts.com](http://www.Express-Scripts.com)
- 1-800-987-8368

**VSP Vision Services**  
Global Choice Plan basic vision coverage.

- [www.vsp.com/go/chevron](http://www.vsp.com/go/chevron)
- 1-800-877-7195 (Inside the U.S.)
- 916-851-5000 (Outside the U.S.) Press “0” for operator assistance.

**ADP Benefit Services**  
COBRA and Continuation Coverage

- 1-888-825-5247 (Inside the U.S.) Select option 2, then “*”
- 610-669-8595 (Outside the U.S.) Select option 2, then “*”
Update to the Summary Plan Description
Effective January 1, 2017

All changes described in this SMM are effective January 1, 2017 unless otherwise indicated.

This enclosed newsletter serves as an official summary of material modification (SMM) for the plans referenced herein. Please keep this information with your other plan documents for future reference. This communication provides only certain highlights about changes of benefit provisions. It is not intended to be a complete explanation. If there are any discrepancies between this communication and the legal plan documents, the legal plan documents will prevail to the extent permitted by law. There are no vested rights with respect to Chevron health care plans or any company contributions towards the cost of such health care plans. Rather, Chevron Corporation reserves all rights, for any reason and at any time, to amend, change or terminate these plans or to change or eliminate the company contribution toward the cost of such plans. Such amendments, changes, terminations or eliminations may be applicable without regard to whether someone previously terminated employment with Chevron or previously was subject to a grandfathering provision. Some benefit plans and policies described in this document may be subject to collective bargaining and, therefore, may not apply to union-represented employees.

You can access the summary plan descriptions for your benefits on the Internet at hr2.chevron.com or by calling the HR Service Center at 1-888-825-5247 (610-669-8595 if you’re outside the U.S.), option 2.

This SMM applies to the following summary plan description:

- January 1, 2014 Global Choice Plan (U.S.-Payroll Expatriates) Summary Plan Description (both the individual SPD posted online and the Your Chevron Health Benefits Summary Plan Description for U.S.-Payroll Employees compilation available in print.)
The Global Choice Plan (U.S.-Payroll Expatriates) is the only medical plan option available to you while you’re on a resident expatriate assignment. The Global Choice Plan offers comprehensive coverage for the medical services you’d expect, including office visits, emergency services, hospital care, lab services, outpatient care, pregnancy and newborn care, and rehabilitative services.

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

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

**Basic Vision**
If you’re enrolled in the Global Choice Plan, you’re automatically covered by the Vision Program for basic vision coverage with VSP.
what’s changing

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

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

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

One of the benefits of the Global Choice Plan is the flexibility to use any U.S. doctor you choose – in or out of the network. Your share of the costs – such as the coinsurance – will often be lower if you use a network provider. This isn’t changing. However, starting January 1, 2017, Cigna will change how your out-of-network claims for covered medical services will be paid, which will affect your costs when you choose to use an out-of-network provider.

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

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

Here’s a simple example of how this works.¹

Assume you’ve met your deductible and you receive a covered service from an out-of-network provider in the United States.

<table>
<thead>
<tr>
<th></th>
<th>Network provider</th>
<th>Out-of-network provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered charge (Billed rate)</td>
<td>$280</td>
<td>$280</td>
</tr>
<tr>
<td>Covered charge (Contracted rate)</td>
<td>$170</td>
<td>$0 No contracted rate available.</td>
</tr>
<tr>
<td>Maximum reimbursable charge (MRC)</td>
<td>Not applicable</td>
<td>$218</td>
</tr>
<tr>
<td>Your coinsurance obligation²</td>
<td>$34 (20% x $170)</td>
<td>$87 (40% x $218)</td>
</tr>
<tr>
<td>Amount above MRC</td>
<td>$0 Not applicable.</td>
<td>$62 Provider may balance bill you directly for this amount. It’s your responsibility to pay this bill.</td>
</tr>
<tr>
<td>Your total out-of-pocket cost</td>
<td>$34 (Your coinsurance)</td>
<td>$149 (Your $87 coinsurance + $62 balance billing amount)</td>
</tr>
</tbody>
</table>

1. This is an example used for illustrative purposes only. Actual covered charges and out-of-pocket costs will vary.
2. Assumes coinsurance of 20% for covered network services and 40% for covered out-of-network services. Your actual coinsurance amount may vary.
prescription drugs obtained inside the U.S.

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

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

You’ll be notified by Express Scripts if your medication is subject to any of these programs during 2017, including what you need to do, if anything. Starting October 17, 2016, to find out if your prescription drug is subject to prior authorization and Drug Quantity Management programs, contact Express Scripts Member Services at 1-800-987-8368, or review the documents and links available from hr2.chevron.com. Click the 2017 Benefit Changes link to get started.

See the information below for a quick review about what prior authorization and Drug Quantity Management means.

- The Prescription Drug Program covers some drugs only if they're prescribed for certain uses (or only up to certain quantity levels). For this reason, some medications will require your prescribing doctor to provide additional clinical information so that use of the medication can be approved in advance before you can receive Prescription Drug Program benefits. This is called prior authorization.

- Drug Quantity Management is a program included in the Prescription Drug Program that’s designed to make the use of prescription drugs safer and more affordable. It provides you with medicines you need for your good health and the health of your covered dependents, while making sure you receive them in the amount — or quantity — considered safe and most cost effective.

2017 employee monthly premium changes

The employee monthly premium will change effective January 1, 2017. See Page 10 for the new monthly cost.
what’s the same

preventive care
The Global Choice Plan includes 100 percent coverage with no deductible for routine preventive care services as specified by the Affordable Care Act. Additional preventive screenings and services may also be covered, depending on factors like your age and gender.

annual deductible
The deductible amounts under the Global Choice Plan are not changing for 2017. See the table included later in this document for the amounts. Here are some reminders about the deductible structure under the Global Choice Plan (U.S.-Payroll Expatriates).

There are two separate deductibles under the Global Choice Plan:
- There is a deductible that applies to all medical services (inside and outside the United States).
- There is a deductible that applies to prescription drugs obtained inside the United States (no deductible for mail-order).

There is no deductible for the following, but copayments or coinsurance may apply:
- Prescription drugs obtained outside the United States.
- Mental health and substance abuse services (inside and outside the United States).

annual out-of-pocket maximum
The out-of-pocket maximums under the Global Choice Plan are not changing for 2017. See the table included later in this document for the maximums. Here are some reminders about the out-of-pocket maximum structure under the Global Choice Plan (U.S.-Payroll Expatriates).

There are two separate out-of-pocket maximums under the Global Choice Plan:
- There is an out-of-pocket maximum that applies to all medical services (inside and outside the United States), all mental health and substance abuse services (inside and outside the United States) and prescription drugs obtained outside the United States.
- There is an out-of-pocket maximum that applies to prescription drugs obtained inside the United States.

save for health care
All of Chevron’s medical plans offer access to one of two tax-advantaged health accounts — either the Health Care Spending Account (HCSA) or a health savings account (HSA). Both accounts can help you pay for certain out-of-pocket health care costs. Enrolling in a health account is a voluntary choice, and the account you can use varies based on the medical plan you choose. As an expatriate, you are eligible to enroll in the Health Care Spending Account (HCSA); you are not eligible to open or contribute to an HSA. If you leave an expatriate assignment mid-year in 2017, you'll be able to enroll in the High Deductible Health Plan (HDHP) or HDHP Basic, if desired. If you enroll in either one of these high deductible health plan options, you may be eligible to open or contribute to an HSA. However, if you already enrolled in the HCSA for 2017, you can enroll in the HDHP or HDHP Basic, but you will not be eligible to open and contribute to an HSA in 2017. This is because you cannot open or contribute to an HSA if you are also are enrolled in a flexible spending account like the Health Care Spending Account (HCSA). Please keep this in mind as you make your enrollment decisions for 2017.
reminders about using your coverage

services outside the United States

All medical services and prescription drugs obtained outside the United States are insured by Cigna.

- Individual providers (such as a doctor), pharmacies and outpatient hospital facilities will generally require payment at the time services are delivered. You'll need to submit a claim directly to Cigna for reimbursement. (See Page 8)

- There are no Cigna networks outside the United States; however Cigna does have a direct settlement agreement with many international providers (physician and hospitals). This means that if you use one of these providers, Cigna can settle your charges directly. Be sure to provide your member ID card when you visit. If Cigna does not have a direct settlement agreement in place, they can, in many cases, arrange for a Guarantee of Payment. You or the provider should contact the 24-hour member services unit at the number on your ID card to make arrangements. Regardless of the direct settlement agreement, you should always obtain a copy of the bill for services rendered and retain it for your records.

- Cigna has more than 185,000 doctors and hospitals with either direct settlement or who are a part of CignaLinks. The CignaLinks program has partnerships with select, regional networks for additional cost savings and ease of access to health care. CignaLinks can also help you understand how health care works in your host country. Contact Cigna for more information about CignaLinks.

- If you need to obtain a prescription when you are outside the United States, Cigna can help you locate a physician. Cigna can also verify if a prescription is available or help you determine the drug equivalency in other countries for your prescription medications.

- If you need to obtain a prescription when you are outside the United States, use your Cigna ID card.

- Mail-order (home delivery pharmacy) is only available through Express Scripts and only applies to addresses within the United States because medications cannot be shipped overseas. In addition, medications cannot be shipped through Chevron pouch mail. (See Page 7 for additional information about obtaining a 365-day supply.)

- If you receive covered basic vision services outside the U.S., the nonpreferred (out-of-network) level of benefits will apply. However, if you use a VSP preferred provider while you're in the U.S., the preferred provider level of benefits will apply for covered materials and services.
services inside the United States

All medical services are insured by Cigna — whether inside or outside the United States. Express Scripts administers your prescription drugs for prescriptions obtained inside the United States or by mail-order within the United States.

- **The Global Choice Plan uses the Cigna Open Access Plus network, so you can use any doctor you choose** – in or out of the network — although you will generally pay less for your out-of-pocket expenses if you use a network provider. Contact Cigna to find a U.S. provider in the Cigna network. (See Page 9.)

- **If you need to obtain a prescription when you are inside the United States, use your Express Scripts ID card.** Your Cigna ID card is only for medical services or when you purchase a prescription outside the U.S.

- **Show your Cigna member ID card to your provider for medical services.** If they have questions about your coverage they should contact Cigna at the phone number listed on your ID card. Note that if you need to obtain a prescription when you are inside the U.S., use your Express Scripts ID card.

- **Covered dependents staying behind in the United States will be issued a card with their own name on it and should always use their own Cigna ID card when receiving medical services.**

- **If you visit a network provider in the United States, you do not need to submit a claim form for reimbursement. You’ll pay out of your own pocket for your portion of the medical service, if any, when you receive it. Your provider will work directly with Cigna. (See Page 8.)**

- **If you visit an out-of-network medical provider in the United States, you will generally need to pay for the service when you receive it, out of your own pocket. Be sure to ask your provider for assistance with completing a Cigna claim form, then return the claim form with the required copies of receipts and bills to Cigna. Remember, you have the choice to use a network or out-of-network provider in the U.S., put you’ll generally pay more out-of-pocket when you choose to use an out-of-network provider.**

- **Mail-order is only available through Express Scripts and only applies to addresses within the United States because medications cannot be shipped overseas. In addition, medications cannot be shipped through Chevron pouch mail.**

Starting January 1, 2017, Cigna will change how your out-of-network claims for covered medical services will be paid, which will affect your costs when you choose to use an out-of-network provider in the United States. See Page 2 to read about the maximum reimbursable charge (MRC) and how it affects your costs.
Reminders about 365-day medication supply

When you are on an expatriate assignment, medications cannot be sent through international mail (including pouch mail). If you require medication on a regular basis, you'll need to plan ahead for your trips back to the United States. You can typically secure a 365 day prescription of daily required medication prior to departure back to your host country. There are no changes to this benefit feature or the process for obtaining a 356-day supply in 2017. The following information is provided as a reminder only. For more specific information about the deductible, copayment and coinsurance, review the Global Choice Plan summary plan description or call Express Scripts at Express Scripts Member Services at 1-800-987-8368.

1. **Speak with your health care provider and request the respective prescriptions.** You may be required to set an appointment with your provider, so plan ahead accordingly.
   - The prescription must be written for **one year** or **365 days** (*not* 30-days with refills)
   - The prescription must include the **dose per day**.
   - The prescriptions must be written by a U.S.-licensed doctor.
   - Be aware that certain controlled substances, by law, may be limited to **less than** a 365 day supply.

2. **Take your prescription to any Express Scripts network pharmacy in the United States.** Remember, prescriptions obtained through the home delivery pharmacy program cannot be mailed to an address outside the U.S. (this includes pouch mail addresses). Chevron cannot control the delivery method or schedule of the home delivery pharmacy. So if your time is limited, you're encouraged to use a **U.S. network retail pharmacy** to fill the prescription.
   - Show your prescription ID card to the pharmacist or provide your Express Scripts ID number when you hand in your prescription.
   - The pharmacist will process your prescription, using the program’s computer system to confirm your eligibility, and make sure the drug is covered under the plan. The computer system may notify the pharmacist if there’s a potential problem with the prescription (such as a risk of adverse interaction with other drugs you’re taking).
how to submit claims

cigna claims
Use the same Cigna claim form for:

- Medical services inside the U.S. If you go to a network provider for care, your provider files the claim for you. If you go to an out-of-network provider for care, you usually have to pay for the service and file a claim to be reimbursed.
- Medical services outside the U.S.
- Prescription drugs obtained outside the U.S.

You should file a claim as soon as you incur a covered charge, even if you haven’t yet paid your deductible. Claim forms are available on the Cigna website. Claims forms are also available on hr2.chevron.com. (Choose the Your Benefits tab and then select the Global Choice (U.S.-Payroll Expatriates) Plan from the page.)

You can submit claim forms and bills by mail, email or fax, or you can submit claims online at CignaEnvoy.com. You are strongly encouraged to submit your claims online at CignaEnvoy.com. It’s the fastest and easiest way to obtain reimbursement. Keep a copy of your completed claim form and receipts for your records. You can track the status of your claim on CignaEnvoy.com and you can contact Cigna if you have any questions. Cigna offers several options for reimbursement including international direct deposit, checks, electronic funds and wire transfers.

express scripts claims
In the situations below you’ll need to pay full price for your medication and send in a completed claim form to Express Scripts to request reimbursement of covered charges.

- Prescription drugs obtained inside the U.S. at an out-of-network pharmacy. If your prescriptions are filled at a network pharmacy or through the program’s home delivery pharmacy, you pay your share of the cost when you order the medication you need. There are no claim forms to fill out.
- Your prescription is filled at a network U.S. pharmacy, but you don’t have your prescription ID and the pharmacist is unable to verify your coverage.
- You submit a request for a prescription drug at a network U.S. pharmacy and your request is denied – for example, your ID card is rejected.

Claim forms are available on the Express Scripts website or by calling Express Scripts Member Services. Claims forms are also available on hr2.chevron.com. (Choose the Your Benefits tab and then select the Global Choice (U.S.-Payroll Expatriates) Plan from the page.) When you fill out the claim form, use your full name and your member ID number located on your Express Scripts ID card. Attach the original receipt from the pharmacy. Mail the completed claim form to the address shown on the form. The receipt must contain the following information:

- Date prescription was filled.
- Name and address of the pharmacy.
- National Drug Code (NDC) number.
- Name of drug and strength.
- Quantity.
- Prescription (Rx) number.
- “Dispense as Written,” if applicable.
- Amount paid for the medication.
## contact information

### Chevron Global Choice Plan (U.S. Payroll Expatriates)

<table>
<thead>
<tr>
<th>Claims administrator</th>
<th>Medical Services</th>
<th>Cigna Global Health Benefits (Cigna) <em>(inside and outside U.S.)</em></th>
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<td></td>
<td>Prescription Drugs</td>
<td>Cigna Global Health Benefits (Cigna) <em>(obtained outside U.S.)</em></td>
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<tr>
<td></td>
<td>Vision Services</td>
<td>VSP Vision Care (VSP) <em>(inside and outside U.S.)</em></td>
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<table>
<thead>
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<th>Group account numbers</th>
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<tr>
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<td></td>
<td></td>
<td>Express Scripts 1839</td>
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<td>Contact Express Scripts</td>
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<tr>
<td></td>
<td>Vision Services</td>
<td>VSP Choice</td>
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<table>
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<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Express Scripts: <a href="http://www.express-scripts.com">www.express-scripts.com</a></td>
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<tr>
<td></td>
<td>Vision Services</td>
<td>VSP: <a href="http://www.vsp.com/go/chevron">www.vsp.com/go/chevron</a></td>
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</table>

<table>
<thead>
<tr>
<th>Phone numbers</th>
<th>Medical Services</th>
<th>1-800-828-5822 (U.S. and Canada)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prescription Drugs</td>
<td>ATT Access Code* + 800-828-5822</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-302-797-3871 (collect calls accepted)</td>
</tr>
<tr>
<td></td>
<td>Vision Services</td>
<td>Cigna: See medical services line above for phone numbers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Express Scripts: 1-800-987-8368</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-800-877-7195</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-916-851-5000 (Press 0 for operator assistance)</td>
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**Global Choice Plan**

**Effective January 1, 2017**

### Covered Medical Services
- Covered Prescription Drugs
- Covered Mental Health and Substance Abuse Services

### 2017 Employee Monthly Premium

<table>
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<tr>
<th>Plan Type</th>
<th>Premium 2017</th>
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<tbody>
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<td>You only</td>
<td>$92</td>
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<tr>
<td>You + One adult</td>
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<tr>
<td>You + Child(ren)</td>
<td>$156</td>
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<tr>
<td>You + Family</td>
<td>$247</td>
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### Annual Deductibles

This is the amount you pay out of pocket before your health plan begins to help pay for covered health care services.

#### Inside U.S. and Outside U.S., Combined

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Deductibles 2017</th>
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<td>You only</td>
<td>$300</td>
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<tr>
<td>You + One adult</td>
<td>$600</td>
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<tr>
<td>You + Child(ren)</td>
<td>$600</td>
</tr>
<tr>
<td>You + Family</td>
<td>$900</td>
</tr>
</tbody>
</table>

### Annual Out-of-Pocket Maximum

This amount is the most you will have to pay out of pocket for covered health care expenses for the year. When you reach this amount, your medical plan begins to pay 100 percent of covered expenses when you receive care outside the U.S. or from network providers in the U.S., or 100 percent of the Maximum Reimbursable Charge (MRC) when you receive care inside the U.S. from an out-of-network provider. This amount is important because it protects you in the event you have a year with major health expenses.

#### Inside U.S.

- **Individual**
  - $150
- **Family**
  - $300

*No deductible for mail-order prescriptions*

#### Outside U.S.

- **No deductible**
- But copayments or coinsurance do apply.

#### Inside U.S. Outside U.S.

- **No deductible**
- But copayments or coinsurance do apply.

#### Inside U.S.

- **Individual**
  - $1,800
- **Family**
  - $3,600

- **Outside U.S.**
  - $2,300
- **All Services**
  - $4,600
- **Outside U.S. and All Services Combined**
  - $6,900

Global Choice Plan (U.S.-Payroll Expatriate)
Chevron has established a tobacco surcharge for Chevron medical and supplemental life insurance coverage. This means there are different monthly rates for this coverage for tobacco and non-tobacco users. The tobacco surcharge information here applies to all active U.S.-payroll employees (and those on a leave of absence). There are no changes to the tobacco surcharge for 2017. However, important reminders about the tobacco surcharge are included here for your reference. Go to hr2.chevron.com for additional details about the tobacco surcharge.
update your tobacco use status for 2017

Open enrollment is your only opportunity to update your tobacco use status for 2017.

Open enrollment — October 17 through October 28, 2016 — is your only opportunity to change your tobacco use status for 2017. If you miss this deadline, you cannot change your 2017 tobacco use status until the next open enrollment period. And you cannot change your 2017 tobacco use status during the year, even if you experience a qualifying life event — like getting married or having a baby.

do I need to do anything during open enrollment?

If your 2016 certification status is Tobacco User, But Commit to Coaching, you may need to take action during open enrollment to update your 2017 tobacco use status.

• If you do not make a new tobacco use certification during open enrollment, your 2017 tobacco use status will be automatically assigned as Tobacco User and the tobacco surcharge will apply to you for all of 2017.

• If you make a new 2017 tobacco use certification during open enrollment, your certification choice will determine whether or not the tobacco surcharge applies to you for all of 2017.

If your 2016 certification status is either Not a Tobacco User, Tobacco User or Decline to Disclose, your 2016 status will continue automatically in 2017 unless you make a change to your status during open enrollment. You do not need to do anything if this designation still accurately describes your tobacco use status.

2017 surcharge amounts

There is no change to the tobacco surcharge amounts effective January 1, 2017 so they continue to be as follows:

• $25 more each month for medical coverage, if enrolled.

• 20 percent more each month for Chevron Supplemental Life Insurance Plan coverage, if enrolled.

how to update your tobacco use status

You can update your tobacco use status October 17 through October 28, 2016, by calling the HR Service Center or by going online to Benefits Connection, the same website you use to make open enrollment elections. Open enrollment instructions will be sent to you in October or you can go to hr2.chevron.com to learn more.

certification choices

Your 2017 tobacco certification choices and requirements are as follows:

• Not a Tobacco User. You will not be subject to the surcharge in 2017.

• Tobacco User. If you’re a tobacco user and don’t intend to stop using tobacco, the surcharge will apply to you in 2017.

• Tobacco User, But Commit to Coaching. If you commit to complete at least three Tobacco Cessation Specialty Coaching sessions through WebMD between July 1, 2016 and December 31, 2017, the surcharge will not apply to you in 2017. Tobacco Cessation Specialty Coaching combines one-on-one telephone coaching, nicotine replacement therapy and integrated online resources to help participants try to stop using tobacco products. Contact WebMD at 1-888-321-1544 (or 925-842-8346 from outside the U.S.) to enroll. You can use this service again, even if your past attempts to quit have been unsuccessful. Go to hr2.chevron.com/wellness to learn more about this and other Tobacco Free Program resources.

• Decline to Disclose. If you decline to disclose your tobacco use, you will be defaulted to Tobacco User and the surcharge will apply to you in 2017.

What’s considered tobacco use?

Indicate your tobacco use status only; you don’t have to certify the tobacco use status of your spouse or domestic partner and other dependents for 2017. The definition of tobacco use has not changed for 2017. Any use, regardless of frequency or location, is considered use. This includes daily, occasional or social use. It also includes if it’s used only at your home. Tobacco use means you’ve used any of the following at any point since July 1, 2016:

• Tobacco (cigarette, pipe, cigar).

• Smokeless tobacco (such as snuff or chewing tobacco).

The Federal Drug Administration now regulates e-cigarettes as tobacco, but they will not be included in the definition of tobacco use for purposes of the 2017 tobacco surcharge. Chevron does, however, intend to change the definition in 2018 to include e-cigarette use as tobacco use.
Update to the Summary Plan Description
Effective January 1, 2016

All changes described in this SMM are effective January 1, 2016 unless otherwise indicated.

This enclosed newsletter serves as an official summary of material modification (SMM) for the plans referenced herein. Please keep this information with your other plan documents for future reference. This communication provides only certain highlights about changes of benefit provisions. It is not intended to be a complete explanation. If there are any discrepancies between this communication and the legal plan documents, the legal plan documents will prevail to the extent permitted by law. There are no vested rights with respect to Chevron health care plans or any company contributions towards the cost of such health care plans. Rather, Chevron Corporation reserves all rights, for any reason and at any time, to amend, change or terminate these plans or to change or eliminate the company contribution toward the cost of such plans. Such amendments, changes, terminations or eliminations may be applicable without regard to whether someone previously terminated employment with Chevron or previously was subject to a grandfathering provision. Some benefit plans and policies described in this document may be subject to collective bargaining and, therefore, may not apply to union-represented employees.

You can access the summary plan descriptions for your benefits on the Internet at hr2.chevron.com or by calling the HR Service Center at 1-888-825-5247 (610-669-8595 if you’re outside the U.S.), option 2.

This SMM applies to the following summary plan description:

- **January 1, 2014 Global Choice Plan (U.S.-Payroll Expatriates) Summary Plan Description**
  (both the individual SPD posted online and the Your Chevron Health Benefits Summary Plan Description for U.S.-Payroll Employees compilation available in print.)
Tobacco Surcharge Changes

New Tobacco User Trying to Quit requirements for 2016.

Open enrollment — October 19 through October 30, 2015 — is your only opportunity to update your tobacco use status for 2016.

Chevron has established a tobacco surcharge for medical and supplemental life insurance coverage. All active U.S.-payroll employees (and those on a leave of absence) were previously required to certify their tobacco use status. Open enrollment — October 19 through October 30, 2015 — is your only opportunity to change your tobacco use status for 2016. If you miss this deadline, you cannot change your 2016 tobacco use status until the next open enrollment period. And you cannot change your 2016 tobacco use status during the year, even if you experience a qualifying life event — like getting married or having a baby.

If your 2015 certification status is Tobacco User, But Will Try to Quit, you may need to take action during open enrollment to update your 2016 tobacco use status. If you do not make a new tobacco use certification during open enrollment, your 2016 tobacco use status will be automatically assigned as Tobacco User and the tobacco surcharge will apply to you for all of 2016. If you make a new 2016 tobacco use certification during open enrollment, your certification choice will determine whether or not the tobacco surcharge applies to you for all of 2016.

If your 2015 certification status is either Not a Tobacco User, Tobacco User or Decline to Disclose, your 2015 status will continue automatically in 2016 unless you make a change to your status during open enrollment. You do not need to do anything if this designation still accurately describes your tobacco use status.

There is no change to the tobacco surcharge amounts. The tobacco surcharge effective January 1, 2016 is as follows:

- $25 more each month in 2016 for medical coverage.
- 20 percent more each month in 2016 for Chevron Supplemental Life Insurance Plan coverage, if enrolled.

How to Update Your Tobacco Use Status

You can update your tobacco use status by calling the HR Service Center (see Page 10) or by going online to Benefits Connection, the same website you use to make open enrollment elections. Follow the instructions on Page 10 to make open enrollment elections and update your tobacco use status for 2016.
Certification Choices for 2016

Your 2016 tobacco certification choices and requirements are as follows:

- **Not a Tobacco User.** You will not be subject to the surcharge during 2016.
- **Tobacco User.** If you’re a tobacco user and don’t intend to stop using tobacco, the surcharge will apply to you in 2016.
- **Tobacco User, But Commit to Coaching.** This is a new certification choice for 2016. See below for details.
- **Decline to Disclose.** If you decline to disclose your tobacco use, you will be defaulted to Tobacco User and the surcharge will apply to you in 2016.

**New for Choice for 2016: Tobacco User, But Commit to Coaching**

If you commit to complete at least three Tobacco Cessation Specialty Coaching sessions through WebMD between July 1, 2015 and December 31, 2016, the surcharge will not apply to you during 2016. Tobacco Cessation Specialty Coaching combines one-on-one telephone coaching, nicotine replacement therapy and integrated online resources to help participants try to stop using tobacco products. Contact WebMD at 1-888-321-1544 (or 925-842-8346 from outside the U.S.) to enroll. You can also go to hr2.chevron.com/wellness to learn more about this and other Tobacco Free Program resources.

**What’s Considered Tobacco Use**

Indicate your tobacco use status only; you don’t have to certify the tobacco use status of your spouse or domestic partner and other dependents for 2016. The definition of tobacco use has not changed for 2016. Any use, regardless of frequency or location, is considered use. This includes daily, occasional or social use. It also includes if it’s used only at your home. Tobacco use means you’ve used any of the following at any point since July 1, 2015:

- Tobacco (cigarette, pipe, cigar).
- Smokeless tobacco (such as snuff or chewing tobacco).

E-cigarettes do not contain tobacco, so at this time e-cigarettes are not included in the tobacco use definition. However, the Federal Drug Administration is currently reviewing e-cigarettes. We continue to monitor this review and may choose to include e-cigarettes in the tobacco use definition in the future.
Global Choice Plan
(U.S.-Payroll Expatriates)

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

- **Medical Services**
  - All medical services are insured by Cigna – whether inside or outside the United States.

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

- **Basic Vision:** Automatically covered by the Vision Program for basic vision coverage with VSP.

Preventive Care
The Global Choice Plan includes 100 percent coverage with no deductible for certain preventive care services as specified by the Affordable Care Act when you see a network provider (100 percent of allowable charges for an out-of-network provider). Additional preventive screenings and services may also be covered, depending on factors like your age and gender.

Deductibles
There are two separate deductibles under the Global Choice Plan:

- There is a deductible that applies to all medical services (inside and outside the United States).
- There is a deductible that applies to prescription drugs obtained inside the United States (no deductible for mail-order).

There is no deductible for prescription drugs obtained outside the U.S., and no deductible for mental health and substance abuse services.

Health Care Spending Account (HCSA)
You are eligible to participate in the Health Care Spending Account (HCSA), a flexible spending account. The funds you contribute to this account do not roll over from year to year. Learn more about the HCSA on hr2.chevron.com. Choose Open Enrollment.

Health Savings Account (HSA)
You cannot participate in a health savings account when enrolled in the Global Choice Plan. However, you can use funds from an existing HSA to pay for qualified medical expenses while participating in the Global Choice Plan.

Mental Health and Substance Abuse (MHSA) Plan
You're automatically covered by the MHSA Plan. You can choose to use any provider, network or out-of-network (there are no network providers outside the United States). There is no deductible to satisfy. See Page 21 for more information about the MHSA Plan.
### Monthly Premium
This is the fixed amount of money you pay each month to be covered by your health plan. Chevron also currently contributes money each month to help pay for your premium.

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<tr>
<th>You Pay</th>
<th>Chevron Pays</th>
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<td>$88</td>
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### Annual Deductible
This is the amount you pay out of pocket before your health plan begins to help pay for covered health care services.

- **Inside the U.S.**
  - Individual: $150, $300 (Family)
  - Outside the U.S.: No deductible, but copayments or coinsurance do apply.

**No deductible for mental health and substance abuse coverage, but copayments or coinsurance do apply.**

### Out-of-Pocket Maximum
This amount is the most you will have to pay out of pocket for covered health care services for the year. When you reach this amount, your health plan begins to pay 100 percent of the allowed amount for covered health care services. This amount is important because it protects you in the event you have a year with major health expenses. Your monthly premium, charges in excess of the allowable charges, and services your plan doesn’t cover are examples of things not included in the out-of-pocket maximum.

- **Medical Services (Inside and Outside the U.S.)**
  - You Only: $2,300
  - You + One Adult: $4,600
  - You + Child(ren): $4,600
  - You + Family: $6,900

- **Prescription Drugs (Inside the U.S.)**
  - Individual: $1,800
  - Family: $3,600

Deductible, copayments, coinsurance, mental health and substance abuse apply toward the out-of-pocket maximum.

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**Tobacco Surcharge**
Chevron has established a tobacco surcharge for medical and supplemental life insurance coverage. This means there are different monthly rates for this coverage for tobacco and non-tobacco users. The rates above do not include a tobacco surcharge. See Page 14 for tobacco surcharge information.

**For More Information**
Be sure to go to [hr2.chevron.com](http://hr2.chevron.com) for access to a variety of other resources.
Changes to Prescription Drug Coverage

Cigna is the insurer for prescription drugs obtained outside the United States. There are no changes to your Cigna prescription drug coverage for 2016.

Express Scripts is the insurer for the Prescription Drug Program which covers prescription drugs obtained inside the United States and through mail order within the United States. The prescription drug changes described in this section apply to your coverage through Express Scripts and take effect on January 1, 2016. For additional details, contact Express Scripts Member Services at 1-800-987-8368, or review the documents and links available from hr2.chevron.com. Choose the Open Enrollment link to get started.

New Medications Subject to Preferred Step Therapy

Certain drugs are covered by the Prescription Drug Program only if preferred drugs – which include generics – are tried first. This is called Preferred Step Therapy (PST). The following are new classes of medications that will be subject to PST effective January 1, 2016. This means that you will be required, when clinically appropriate, to try a preferred drug before Express Scripts will authorize coverage for the use of non-preferred drugs:

- **Topical Acne**
  (For example: Cleocin T, Ancanya, Ziana, Veltin, Benzac AC, Azelex)

- **Topical Corticosteroids**
  (For example: Synalar, Cordran, Halog, Topicort, Diprolene)
New Prior Authorizations

The Prescription Drug Program covers some drugs only if they’re prescribed for certain uses or only up to certain quantity levels. For this reason, some medications will require your doctor to provide additional clinical information so that use of the medication can be approved in advance before you can receive plan benefits. This is called prior authorization. The following drugs will require prior authorization effective January 1, 2016:

- Anticoagulants (Pradaxa, Xarelto, Eliquis)
- Suboxone

Some Compound Medications Not Covered

According to the FDA, compounding is the practice in which a licensed pharmacist combines, mixes or alters ingredients in response to a prescription to create a medication tailored to the medical needs of an individual patient. Individual active ingredients within the compound might be FDA approved, but the FDA does not approve the quality, safety and efficacy of the actual compound with multiple active ingredients.

A number of commonly used primary ingredients for compounds have been identified and will no longer be covered by the Chevron Prescription Drug Program. Beginning January 1, 2016, if you are using a compound medication in which the primary ingredient is no longer covered, then the compound medication will no longer be covered.

For a few of the excluded compound medications, there are commercially available products that don’t require a compounded product. Only your medical provider and you can determine a suitable alternative since it is often difficult to determine the condition for which a compound medication is being prescribed. If you continue to use the affected compound medications, you will pay the full retail price if you refill that prescription starting January 1, 2016.

Please note that not all compounded prescriptions are being excluded from coverage. There is still an inclusion list of compound ingredients that will remain covered and are considered appropriate. For example, certain pediatric compounds remain covered.

If you are currently taking or are prescribed a compound medication, you can call Express Scripts Member Services at 1-800-987-8368 to verify if your medication is covered or excluded. After January 1, 2016, you can also go to the Express Scripts website at www.express-scripts.com and search for your medication to verify the coverage status.
PCSK9 Inhibitor Drug Class
New Prior Authorization Program

The FDA has approved the first formulas in a new class of cholesterol-lowering maintenance drugs called PCSK9 inhibitors. These new drugs are self-injectable specialty medications. Although studies are still underway, PCSK9 inhibitors may be used alone or in combination with current statin drugs to further lower the hardest-to-treat elevated cholesterol levels for patients who cannot tolerate any statin drug. This new generation of injectable biologics could offer an alternative for statin-intolerant patients.

While these new drugs will offer an alternative to statins, they may not be right for everyone. In addition, these drugs have the potential to drastically increase prescription drug costs under our Global Choice Plan for both you and Chevron.

In an effort to provide appropriate access to this new class of drugs while protecting plan costs, Express Scripts started the Cholesterol Care Value Program. This is a separate prior authorization program designed specifically for the new PCSK9 inhibitor drug class. This prior authorization program features:

- **A clinical review process by a dedicated clinical team.** With every new request for PCSK9 inhibitors, a dedicated Express Scripts clinical team, with pharmacists who specialize in cardiovascular disease, will employ a robust clinical review, which includes collecting clinical documentation and holding discussions with your physician, before approving your use of a PCSK9 inhibitor.

- **Enhanced care for patients starting PCSK9s.** If you’re changing therapy, you will automatically receive assistance and education from the Cholesterol Care team at Accredo, the Express Scripts specialty pharmacy. Accredo, will initially dispense three, 30-day prescriptions to ensure therapy tolerance before moving to a 90-day fill.

If you have questions, contact Express Scripts Member Services at 1-800-987-8368.
Update to the Summary Plan Description
Effective January 1, 2015

All changes described in this SMM are effective January 1, 2015 unless otherwise indicated.

This enclosed newsletter serves as an official summary of material modification (SMM) for the plans referenced herein. Please keep this information with your other plan documents for future reference. This communication provides only certain highlights about changes of benefit provisions. It is not intended to be a complete explanation. If there are any discrepancies between this communication and the legal plan documents, the legal plan documents will prevail to the extent permitted by law. There are no vested rights with respect to Chevron health care plans or any company contributions towards the cost of such health care plans. Rather, Chevron Corporation reserves all rights, for any reason and at any time, to amend, change or terminate these plans or to change or eliminate the company contribution toward the cost of such plans. Such amendments, changes, terminations or eliminations may be applicable without regard to whether someone previously terminated employment with Chevron or previously was subject to a grandfathering provision. Some benefit plans and policies described in this document may be subject to collective bargaining and, therefore, may not apply to union-represented employees.

You can access the summary plan descriptions for your benefits on the Internet at hr2.chevron.com or by calling the HR Service Center at 1-888-825-5247 (610-669-8595 if you’re outside the U.S.), option 2.

This SMM applies to the following summary plan description:

- **January 1, 2014 Global Choice Plan (U.S.-Payroll Expatriates) Summary Plan Description** (both the individual SPD posted online and the Your Chevron Health Benefits Summary Plan Description for U.S.-Payroll Employees compilation available in print.)
How to Certify
Your Tobacco Use Status

All employees (including U.S.-payroll expatriates on a residential assignment) are required to certify their tobacco use status during open enrollment, October 20 through October 31, 2014.

During this year’s open enrollment period, October 20 through October 31, 2014, all U.S.-payroll employees who participate in Chevron medical or supplemental life insurance coverage will be required to certify their tobacco use status. If you fail to follow the steps to certify your tobacco use status during open enrollment, you’ll be charged the higher monthly rates for medical and supplemental life insurance coverage for all of 2015, whether or not you use tobacco. You will not lose your coverage in these plans if you fail to certify, but you will pay the higher rate. If you miss the deadline, you cannot change your tobacco use status until next year’s open enrollment for 2016 benefits.

Tobacco use can affect your health. And your health is important to your quality of life, your family, your career, and the health of our business. That’s why Chevron announced an important change to medical and supplemental life insurance coverage earlier this year. Starting January 1, 2015, Chevron will establish a tobacco surcharge for medical and supplemental life insurance coverage. This means there will be different monthly rates for this coverage for tobacco and non-tobacco users.

It matters to Chevron that you’re in good health at work and at home. That’s why we offer a variety of wellness programs and resources to encourage and support better health. We hope our employees – tobacco and non-tobacco users alike – take advantage of these opportunities, whether it’s to try to stop using tobacco, participate in exercise programs, or take steps to protect your heart.

How to Certify

You can certify your tobacco use status by calling the HR Service Center (see Page 6) or by going online to Benefits Connection, the same website you use to make open enrollment elections. If you access Benefits Connection, from the Chevron network, you can use the automatic sign-in feature and you don’t need a PIN. But if you need to certify your tobacco use status from outside the Chevron network or by phone, you’ll need your PIN. A PIN reminder was mailed to you in September, but if you still don’t know your PIN or can’t find it, you can request a new one online or by calling the HR Service Center. It can take up to two weeks to receive your PIN in the mail, so take action right away if you need it.

- Go to hr2.chevron.com and click Open Enrollment, then the Certify Tobacco Status button.
- Login to Benefits Connection. Choose the Enroll Today button, then the Make Your Elections Now button.
- From the Make Coverage Elections screen, look for Tobacco Certification and choose Change.
- After you certify your tobacco use status, your Make Coverage Elections screen will be updated according to your certification choice.
Your Certification Choices

When you certify your tobacco use status, you’ll be asked to choose from the status options listed below. Here’s what those choices are and what they mean.

**Tobacco User**

Tobacco use is a personal choice. It’s not our goal to intrude on your personal life and take away that choice. That’s why if you currently use tobacco, you can continue using it. If you’re a tobacco user and don’t intend to stop using tobacco, you’ll pay $25 more each month in 2015 for medical coverage than employees who are not tobacco users. If you participate in Chevron’s Supplemental Life Insurance Plan, you’ll also pay 20 percent more each month in 2015 for that coverage. The higher rates will take effect on January 1, 2015. Your benefit plan and the level of coverage you receive will be the same as non-tobacco users, the only difference will be that you pay a higher monthly cost for your coverage.

**Tobacco User, But Will Try to Quit**

If you commit to try to stop using tobacco during 2015, we have support resources to help you, and you’ll pay the lower monthly rate too. Go to [hr2.chevron.com](http://hr2.chevron.com) for resources.

**Not a Tobacco User**

If you don’t use tobacco you will not be subject to the higher medical and supplemental life insurance rates in 2015 as long as you certify your tobacco use status during open enrollment, October 20 through October 31. If you fail to meet this deadline, you’ll be charged the higher monthly rates for medical and supplemental life insurance coverage for all of 2015.

**Decline to Disclose**

You can choose to decline to disclose your tobacco use status, but you’ll be charged the higher monthly rates for medical and supplemental life insurance coverage for all of 2015, whether or not you use tobacco.

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**What’s considered tobacco use?**

You’ll be asked to indicate your tobacco use status only. You don’t have to certify the tobacco use status of your spouse or domestic partner and other dependents for 2015. Any use, regardless of frequency or location, is considered use. This includes daily, occasional or social use. It also includes if it’s used only at your home. Use of the following since July 1, 2014, will be considered tobacco use:

- Tobacco (such as cigarette, pipe, cigar).
- Smokeless tobacco (such as snuff or chewing tobacco).

E-cigarettes do not contain tobacco, so at this time e-cigarettes are not included in the tobacco use definition. However, the Federal Drug Administration is currently reviewing e-cigarettes. We continue to monitor this review and may choose to include e-cigarettes in the tobacco use definition in the future.
Prescription Drug Changes

The changes described in this section take effect on January 1, 2015

Prescription Drug Coverage – Obtained Outside the U.S. (Cigna)

Cigna is the insurer for prescription drugs obtained outside the United States. There are no changes to this coverage for 2015. Contact Cigna if you have questions. (See Page 29.)

Prescription Drug Coverage – Obtained Inside the U.S. and Through Mail Order (Prescription Drug Program - Express Scripts)

For additional details about the changes described on the following pages, contact Express Scripts Member Services at 1-800-987-8368, or review the documents and links available from hr2.chevron.com. Choose the Open Enrollment link to get started.
Prescription Drug Out-of-Pocket Maximum
For prescriptions filled in the United States. This maximum generally includes your prescription drug deductible, copayments and coinsurance.

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<tr>
<td>You Only</td>
<td>$1,800</td>
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<tr>
<td>You + Family</td>
<td>$3,600</td>
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Compound Medications Not Covered Without Prior Authorization
According to the FDA, compounding is the practice in which a licensed pharmacist combines, mixes or alters ingredients in response to a prescription to create a medication tailored to the medical needs of an individual patient. Individual active ingredients within the compound might be FDA approved, but the FDA does not approve the quality, safety and efficacy of a compound with multiple active ingredients. Express Scripts has identified 10 commonly used bulk powder ingredients (if submitted as the primary ingredient) that have limited or no medical studies for topical use. These bulk powders are:

- Gabapentin
- Fluticasone
- Ketoprofen
- Ketamine
- Diclofenac
- Meloxicam
- Haluronic Acid
- Flurbiprofen
- Mometasone
- Nabumetone

Beginning January 1, 2015, if you are using a compound medication in which the primary ingredient is one of the bulk powders listed above, the medication will no longer be covered without a Prior Authorization. Approval for a Prior Authorization will require clinically sound studies proving the efficacy of the medication. Express Scripts recommends that you contact your physician to try a commercially available, FDA-approved alternative. For a few of the powders, there are commercially available products that don’t require a compounded product. Only your medical provider and you can determine a suitable alternative since it is often difficult to determine the condition for which a compounded medication is being prescribed. If you continue to use the affected compounded medications without an approved Prior Authorization, you will pay the full retail price if you refill that prescription starting January 1. Express Scripts will continue to monitor this class of medications closely.
New National Preferred Formulary

A formulary is a list of drugs that are covered by your plan. It includes commonly prescribed medications that have been selected based on their clinical effectiveness, safety and opportunities for savings. Effective January 1, 2015, your plan will switch to the National Preferred Formulary. While many of the same drugs will continue to be covered, there are approximately 65 drugs that will no longer be covered. See below for the list of drugs that will no longer be covered. If you continue to use any of these drugs, you will pay the full retail price when you refill that prescription starting January 1. If you are taking one of the drugs that will no longer be covered, Express Scripts will notify you starting in October. You will receive a personalized list of alternatives that are available on the formulary, so you can discuss them with your doctor and change your prescription in advance of January 1.

Excluded Medications and Products Effective January 1, 2015

| Abbott (FreeStyle, Precision) | Epogen | Novolin | Testim |
| Abstral | Euflexxa | NovoLog | Testosterone 1% Gel |
| Alvesco | Fentora | Nutropin/Nutropin AQ | Teveten HCT |
| Apidra | Flovent Diskus/HFA | Omnaris | Tev-Tropin |
| Aranesp | Follistim AQ | Omnitrope | Tradjenta |
| Axert | Fortesta | Pancreaze | Ultrasa |
| Bayer (Breeze, Contour) | Frova | PegIntron | Veltin |
| Beconase AQ | Gel-One | Pertzye | Veramyst |
| BenzaClin Gel Pump | Hylgan | Proventil HFA | Victoza |
| Betaseron | Incivek | Roche (Accu-Chek) | Vimo |
| Bravelle | Jentadueto | Saizen | Vogelx |
| Breo Ellipta | Kadian | Simponi | Xeljanz |
| Cetraxal | Kazano | Staxyn | Xopenex HFA |
| Cimzia | Levitra | Stendra | Zetona |
| Duexis | Nesina | Subsys | Zioptan |
| Edarbi/Edarbyclor | Nipro (TRUEtest, TRUEtrack) | Supartz | Zohydro ER |

Is my prescription on the formulary?

To determine at any time if a prescription drug is on the formulary you can:

- Call and ask a Patient Care Advocate at Express Scripts to check on the status of the medication.
- Register and login to [www.express-scripts.com](http://www.express-scripts.com), click on the **Manage Prescriptions** tab at the top of the page, then click on **Price a Medication**.
- Download the Express Scripts mobile app for free, register and then check status of a medication.
Breast Cancer Risk-Reducing Medications
In accordance with the Health Care Reform law, your plan will provide network coverage at 100 percent with no deductible for certain breast cancer risk-reducing medication such as Tamoxifen and Raloxifene. You’re eligible for the 100 percent coverage if you meet all of the following requirements:

• You are a woman age 35 or older.
• You do not have a prior history of a diagnosis of breast cancer, ductal carcinoma in situ (DCIS), or lobular carcinoma in situ (LCIS).
• You are being prescribed tamoxifen or raloxifene for the purpose of primary prevention of invasive breast cancer because you are deemed high risk.
• You are post-menopausal, if prescribed raloxifene (this does not apply to a woman prescribed tamoxifen).

Breast cancer risk-reducing medications that are covered are:

• Generic tamoxifen
• Generic raloxifene
• Brand Soltamox (tamoxifen liquid*)

* Tamoxifen liquid will be covered at 100 percent with no deductible if the prescriber provides information that the patient meets all other criteria and cannot swallow or has difficulty swallowing tamoxifen tablets.

Coverage at 100 percent is not automatic. If you meet the eligibility criteria above, you or your provider must request the $0 copayment/coinsurance within 30 days of the prescription being filled (pre- or post-fill). To request the $0 copayment/coinsurance, follow these steps:

• You or your prescriber contacts Express Scripts Customer Service at 1-800-987-8368.
• Customer service will explain the procedure for contacting the Coverage Review Department through mail, fax, or a direct call transfer.
• You will submit your request through mail, fax or telephone.
• Your prescriber is contacted through a fax form to determine if you meet the eligibility criteria.
• Copayment review decision is then made.
• You and your prescriber are notified of decision.

New Prior Authorizations
The Prescription Drug Program covers some drugs only if they’re prescribed for certain uses or only up to certain quantity levels. For this reason, some medications must be approved in advance before you can receive plan benefits. The following drugs will require prior authorization effective January 1, 2015:

• Lovaza
• Vescepa (fish oil)
Who’s Eligible to Participate

This section provides information about benefit plan eligibility for the Global Choice Plan (U.S.-Payroll Expatriates).
Eligible Employees

You are considered a U.S.-payroll expatriate if all of the following apply:

- You are paid on the U.S. dollar payroll.
- You are receiving an expatriate payroll premium.
- Your work location is outside the continental U.S.
- You are assigned to and working in that location on an expatriate assignment that is expected to last for at least three months.
- You are not on a rotational expatriate assignment.

Note: This plan only applies to U.S.-payroll resident expatriates (as described above). This plan is your only option for Chevron-sponsored medical coverage as a U.S.-payroll expatriate. If you are an expatriate working in the United States and you are not on the U.S.-payroll, refer to the Health Benefits for Expatriates in the U.S. summary plan description for information about the Global Choice Plan coverage that applies to you.

Except as described below, you’re generally eligible for this plan if you’re considered by Chevron to be a common-law employee of Chevron Corporation or one of its subsidiaries that it has designated to participate in the Omnibus Health Care Plan and you meet all of the following qualifications:

- You’re paid on the U.S. payroll of Chevron Corporation or a participating company.
- You’re assigned to a regular work schedule (unless you’re on a family leave, disability leave, short union business leave, furlough leave, military service leave or leave with pay) of at least 40 hours a week, or at least 20 hours a week if such schedule is an approved part-time work schedule under the Corporation’s part-time employment guidelines.
- If you’re a casual employee, you’ve worked (or are expected to work) a regular work schedule for more than four consecutive months.
- If you’re designated by Chevron as a seasonal employee, you’re not on a leave of absence.
- You’re in a class of employees designated by Chevron as eligible for participation in the plan.
However, you’re not eligible if any of the following applies to you:

- You’re not on the Chevron U.S. payroll, or you’re compensated for services to Chevron by an entity other than Chevron — even if, at any time and for any reason, you’re deemed to be a Chevron employee.

- You’re a leased employee or would be a leased employee if you had provided services to Chevron for a longer period of time.

- You enter into a written agreement with Chevron that provides that you won’t be eligible.

- You’re not regarded by Chevron as its common-law employee and for that reason it doesn’t withhold employment taxes with respect to you — even if you are later determined to have been Chevron’s common-law employee.

- You’re a member of a collective bargaining unit (unless eligibility to participate has been negotiated with Chevron).

- You’re eligible to receive benefits from the Chevron International Healthcare Assistance Plan (IHAP).

- You’re a professional intern.

You may become eligible for different benefits at different times. Participation and coverage do not always begin when eligibility begins. Chevron Corporation, in its sole discretion, determines your status as an eligible employee and whether you’re eligible for the plan. Subject to the plan’s administrative review procedures, Chevron Corporation’s determination is conclusive and binding.

If you have questions about your eligibility for this plan, please contact:

Chevron Human Resources Service Center
P.O. Box 199708
Dallas, TX 75219-9708
1-888-825-5247 (610-669-8595 outside the U.S.)
Eligible Dependents

If you enroll for coverage under the Global Choice Plan (U.S.-Payroll Expatriates), you also may enroll your eligible dependents for coverage under the same plan (subject to certain restrictions if you are married to or in a domestic partnership with another Chevron employee or retiree). Eligible dependents include your spouse/domestic partner and eligible children, as all are defined below. For more information regarding enrollment procedures, see the Participation section.

Eligible Spouse
If you’re legally married under the law of a state or other jurisdiction where the marriage took place, you can enroll your spouse for coverage — under the same medical plan you’re enrolled in. However, you can’t enroll your spouse for coverage if he or she is any of the following:

- Enrolled as an eligible employee.
- Enrolled as an eligible retiree.
- On active duty in the armed forces of any state, country or international authority.

If both you and your spouse are eligible employees or eligible retirees, each of you can enroll for individual coverage, or one of you can cover the other as a dependent. However, only one of you can enroll all of your children for coverage.

Before you can enroll your spouse for coverage, you may be required to provide proof that you’re legally married.

Eligible Domestic Partner
To qualify for benefits available to domestic partners of Chevron employees, you must register your partner with Chevron. To do so, you and your partner must obtain and sign the Chevron Affidavit of Domestic Partnership (F-6) form.

This form is available through the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). The original of the affidavit form must be notarized and sent to the HR Service Center. By signing the affidavit, you certify that you and your partner meet one of the following qualifications:

1. You and your partner are all of the following:
   - At least age 18 and of legal age.
   - Mentally competent to enter into contracts.
   - Jointly responsible for each other’s welfare and financial obligations and have lived together for at least six months prior to signing the affidavit.
   - In an intimate, committed relationship of mutual caring that has existed for at least six months prior to the signing of the affidavit and it is expected to continue indefinitely.
   - Not related by blood.
   - Not married to anyone other than each other.
2. You live in California and meet all of the requirements of the California Family Code section 297 definition of a domestic partner, including the requirement to have registered your domestic partner with the Secretary of State’s office. For more information, visit the California Domestic Partnership website at www.ss.ca.gov/business/sf/sf_dp.htm.

3. You live in another state (such as Colorado, Delaware, Illinois, Nevada, New Jersey, Oregon, Rhode Island, Vermont, Washington, and others) that recognizes civil unions or state-recognized domestic partnerships and have entered into a civil union or state-recognized domestic partnership and reside in that state.

4. You and your partner have entered into a civil union in a state that recognizes civil unions, but reside in a state where that civil union is not recognized.

5. You meet other criteria set forth in the Chevron Affidavit of Domestic Partnership.

Note that you must enroll your domestic partner and his or her eligible children within 31 days of the date you first meet one of the qualifications listed above. Also, the Chevron Affidavit of Domestic Partnership (F-6) form must be completed and notarized within the 31 days. Otherwise, you must wait until the next open enrollment. For information about imputed income and before-tax vs. after-tax contributions for domestic partners, see the Participation section.

Generally, you can enroll your registered domestic partner for health coverage — under the same plan(s) you’re enrolled in. You can’t enroll your domestic partner for coverage if he or she is any of the following:

- Enrolled as an eligible employee.
- Enrolled as an eligible retiree.
- On active duty in the armed forces of any state, country or international authority.
- If both you and your domestic partner are eligible employees and/or eligible retirees, each of you can enroll for individual coverage, or one of you can cover the other as a dependent. However, only one of you can enroll all of your children for coverage.
Eligible Children and Other Dependents

You can enroll a dependent child for coverage if he or she is all of the following:

- You or your spouse’s/domestic partner’s natural child, stepchild, legally adopted child, foster child, or a child who has been placed with you or your spouse/domestic partner for adoption.


You can enroll an “other dependent” for coverage if he or she is all of the following:

- Not married.

- Younger than age 26. Coverage continues until the end of the month in which your other dependent turns age 26.

- Is a member of your household.

- Someone for whom you act as a guardian.

- Dependent on you (or on your spouse/domestic partner) for more than 50 percent of his or her financial support.

Coverage can continue after the child reaches age 26, provided he or she is enrolled in the plan and meets the plan’s definition of incapacitated child as outlined in the Glossary. When the child reaches age 26 and periodically thereafter, Chevron Corporation will require you to provide documentation stating that the child continues to be incapacitated.

Incapacitated children over age 26 can be added to coverage only if they were disabled before age 26 and had other health care coverage immediately before being added as a dependent under a Chevron plan. You will be required to provide documentation of both conditions. Incapacitated children added after age 26 can include a brother, sister, stepbrother or stepsister if he or she meets the definition of incapacitated child as outlined in the Glossary.

For chronic disabilities, as determined by UnitedHealthcare, you must provide documentation every two years. If the disability is not chronic, UnitedHealthcare will determine how frequently you will need to provide such documentation. For details, contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).

Your child or other dependent isn’t eligible for coverage if he or she is any one of the following:

- Covered as a dependent by another eligible employee or eligible retiree.

- Covered as an eligible employee.

Before your child can be enrolled, you may be required to provide proof of his or her eligibility.
Qualified Medical Child Support Order (QMCSO)
Pursuant to the terms of a qualified medical child support order (QMCSO), the plan also provides coverage for your child, even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment season restrictions that might otherwise exist for dependent coverage. If you are not enrolled in a medical plan, you must enroll for coverage for yourself and the child. If the plan receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency can enroll the affected child. Additionally, Chevron can withhold any contributions required for such coverage.

A QMCSO may be either a National Medical Support Notice issued by a state child support agency or an order or a judgment from a state court or administrative body directing Chevron to cover a child under the plan. Federal law provides that a QMCSO must meet certain form and content requirements in order to be valid. If you have any questions or if you would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).

You, a custodial parent, a state agency or an alternate recipient can enroll a dependent child pursuant to the terms of a valid QMCSO. A child who is eligible for coverage pursuant to a QMCSO cannot enroll dependents for coverage under the plan.
Participation

This section provides a description of the eligibility requirements to participate in the Global Choice Plan (U.S.-Payroll Expatriates).
# A Snapshot of What to Do When

The following chart highlights when and how to enroll in the following plans.

<table>
<thead>
<tr>
<th>Plan</th>
<th>When to Enroll</th>
<th>How to Enroll</th>
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</table>
| **Global Choice Plan** (U.S.-Payroll Expatriates) (includes prescription drug and basic vision coverage) | If you are covered under another Chevron medical plan option and are moved to a resident expatriate assignment, you and your covered dependents will automatically be enrolled in the Global Choice Plan as of the first day of the month following the effective date of your expatriate assignment.  
If you are newly hired to Chevron, you can enroll yourself and your eligible dependents during your first 31 days on the job, if you’re eligible.  
Otherwise, you can enroll yourself and your eligible dependents at any of the following times:  
• During open enrollment.  
• Within 31 days of a qualifying life event.  
Note: To be eligible for the Mental Health and Substance Abuse Plan, your dependents must be enrolled in one of the Chevron-sponsored medical plans. | To enroll, contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). Be sure to complete and turn in any forms sent to you with your confirmation statement.  
Before a dependent’s enrollment is processed, you may be required to provide proof of his or her eligibility (that is, a marriage license, a birth certificate or adoption papers). In addition, before you can enroll your domestic partner for medical plan coverage, you must file a notarized Chevron Affidavit of Domestic Partnership (F-6) form. To request a form, call the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).  
If you don’t enroll your eligible dependents at the same time you enroll yourself, you can enroll them during any annual open enrollment period or within 31 days of the date they first become eligible (for example, within 31 days of a qualifying life event). |
| **Before-Tax Contribution Plan** | If you enroll in a health plan to which Chevron contributes, you’re automatically enrolled to have before-tax deductions for any medical and dental plans. | Not applicable for medical and dental, unless you elect not to enroll. If you don’t want to enroll, decline before-tax participation before your health plan coverage begins by contacting the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). |
Before-Tax vs. After-Tax Contributions

If you enroll to have before-tax deductions taken for this plan, you will be automatically enrolled in the Before-Tax Contribution Plan. Most employees benefit by making health plan contributions on a before-tax basis. However, when you make before-tax contributions, you limit your ability to make enrollment changes in your health plans during the year. Also, if you make contributions on a before-tax basis for medical coverage, you are required to make contributions on a before-tax basis for dental coverage and vice versa. When you make after-tax contributions, you have more flexibility to make changes during the year, such as dropping coverage for yourself or an eligible dependent.

When you make before-tax contributions, federal law allows you to make enrollment changes during the year only if the change is allowed under plan rules and one of the following applies:

- The change doesn’t affect the total amount of your monthly before-tax contributions.
- The change is a result of a qualifying life event. (In this case, any change you make must be consistent with the qualifying life event.)

Making before-tax contributions may lower your Social Security benefits slightly if you earn less than the Social Security wage base (which is $117,000 in 2014 and may change each year). However, the advantages of current tax savings may outweigh the possible reduction in your Social Security benefits at retirement. If you earn more than the Social Security wage base, you won’t save any Social Security tax by making before-tax contributions, and your future Social Security benefits won’t be reduced.

Congress may change the laws that govern before-tax contribution programs. Chevron will notify you if you’re affected by any changes in the laws.
Imputed Income and Before-Tax vs. After-Tax Contributions for Domestic Partners

Before you enroll your domestic partner in Chevron benefits, remember that the federal government does not recognize domestic partnerships. Thus, with a very limited exception described below, the fair market value of the benefits provided for your domestic partner and his or her eligible children (unless they also are your natural or adopted children) is considered by the federal government to be “imputed income” that is taxable income to you. The imputed income amount will be added to each of your paychecks, and Chevron will deduct applicable taxes (such as federal, state, and Social Security) each pay period. Whether there is imputed state income depends upon the state. There currently will not be imputed income for state purposes if you qualify under the criteria noted below. Because the federal government does not recognize domestic partnerships, you also cannot pay for the benefits of your domestic partner or his or her children (unless such child is also your natural or adopted child) on a before-tax basis. This does not, however, affect your ability to pay for your benefits on a before-tax basis. As a result, you may see two deductions on your paycheck stub — one for before-tax contributions for your coverage and one for after-tax contributions for coverage for your domestic partner's and his or her eligible children (who also are not your natural or adopted children).

The one exception to imputed federal income to you is if your domestic partner and/or his or her children (unless they are your natural or adopted children — in which case, they are treated just as any other children of an employee) qualify as your dependent as defined in Internal Revenue Code section 152 and you are able to claim them as a dependent on your federal income tax return.

If one of the following applies to you then you may not be subject to imputed income for state tax purposes:

- You live in California and meet all of the requirements of the California Family Code section 297 definition of a domestic partner, including the requirement to have registered your domestic partner, with the Secretary of State's office. For more information, visit the California Domestic Partnership website at [www.ss.ca.gov/business/sf/sf_dp.htm](http://www.ss.ca.gov/business/sf/sf_dp.htm). If you reside in California, you will be exempt from imputed income if you report that your domestic partner meets the state's requirement of a tax dependent and you report that you have registered your domestic partner with the Secretary of State.

- You live in another state such as Oregon or the District of Columbia that recognizes domestic partnerships and you meet that state’s requirements to cover your domestic partner on a before-tax basis. Check with your tax advisor about the tax treatment of coverage.

Before you enroll your domestic partner in Chevron benefits, request and complete the “domestic partner” package that includes important forms and personalized information about benefits enrollment, taxes and beneficiaries. Contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.) to speak with a Customer Service representative.
Making Changes

You can make changes to some of your benefit elections at any time. Other changes can be made only during annual open enrollment (which is typically held during a two-week period each fall) or when there’s a qualifying life event during the year. If you want to add or delete dependents or cancel coverage, contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). However, you cannot change to another Chevron-sponsored health plan while you are a U.S.-payroll expatriate.

The following chart includes a brief explanation of the changes you can make under coverage related to the Global Choice Plan (U.S.-Payroll Expatriates).

<table>
<thead>
<tr>
<th>Plan</th>
<th>Types of Changes</th>
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| Global Choice Plan (U.S.-Payroll Expatriates) (includes prescription drug and basic vision coverage) | • You can change your medical plan elections only:  
  ⎯ During open enrollment. Changes take effect the following January 1.  
  ⎯ During the year if you or a dependent qualify for special enrollment or have a qualifying life event.  
• If you pay for your coverage on an after-tax basis, however, you can cancel your coverage or drop dependents from coverage at any time. |
| Before-Tax Contribution Plan                                         | • You can change the tax status of your health plan contributions (before-tax to after-tax or vice versa) during any open enrollment. Changes take effect the following January 1.  
  You can’t otherwise change your plan elections unless there’s a qualifying life event. |

Midyear Changes

If you pay for your medical coverage on a before-tax basis, because of the plan’s tax advantages, the Internal Revenue Service (IRS) restricts your ability to make changes to your benefits after initial enrollment. In general, once you enroll for (or decline) coverage, your benefit elections stay in effect for the entire plan year. However, under certain circumstances, you can enroll for or change certain coverages during the year (for example, if you experience a qualifying life event that affects your, your spouse’s/domestic partner’s or your dependent’s eligibility for plan benefits).
Qualifying Life Events
You can change certain benefit elections during the plan year if you experience a qualifying life event that results in a loss or gain of eligibility under the plan for yourself, your spouse/domestic partner or your dependent children. Changes can be made to your medical and dental coverage as long as the changes are consistent with, and correspond to, the qualifying life event.

A qualifying life event is any of the following circumstances that may affect coverage:

- You get divorced or legally separated, you have your marriage annulled or your domestic partnership ends.
- Your spouse/domestic partner or dependent child dies.
- Your dependent child becomes eligible or ineligible for coverage (for example, he or she reaches the plan’s eligibility age limit).
- You get married or acquire a domestic partner.
- You have a baby, adopt a child or have a child placed with you for adoption.
- You, your spouse/domestic partner or your dependent child experiences a change in employment status that affects eligibility for coverage (for example, a change from part-time to full-time or vice versa, or commencement of or return from an unpaid leave of absence).
- You, your spouse/domestic partner or your dependent child experiences a significant change in the cost of coverage. This does not apply to the Health Care Spending Account (HCSA) Plan.
- You, your spouse/domestic partner or your dependent child qualifies for or loses Medicare or Medicaid coverage.
- The plan receives a qualified medical child support order (QMCSO) or other court order, judgment or decree requiring you to enroll a dependent in the plan.
- You commence or return from a leave of absence under the Family and Medical Leave Act of 1993 (FMLA).
- You qualify for a special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you experience a qualifying life event and need to change your coverage during the plan year, notify the HR Service Center within 31 days of the date of the event that necessitates the change. If you don’t, you can’t make a coverage change until the next annual open enrollment, unless you have another qualifying life event.
Special Enrollment Rights Under HIPAA
Special enrollment rights apply due to a loss of other coverage or a need to enroll because of a new dependent’s eligibility.

If you are eligible for special enrollment rights under HIPAA, you may enroll in any health plan option offered under the Omnibus Health Care Plan for which you are eligible or, if you’re already enrolled in a health plan option, you may change health plan options if another option is available. However, the only health plan option available to U.S-payroll expatriates is the Global Choice Plan.

Special Enrollment Due to Loss of Other Coverage
You and your eligible dependents can enroll for medical coverage (subject to certain conditions) if you waived your initial coverage at the time it was first offered under this plan because you (or your spouse/domestic partner or dependent) were covered under another plan or insurance policy. You can enroll, provided you or your dependents’ other coverage was either of the following and you meet the conditions described below:

- COBRA continuation coverage that has since ended.
- Coverage (if not COBRA continuation coverage) that has since terminated due to a loss of eligibility,” a loss of employer contributions or for the other reasons described below.

“Loss of eligibility” includes a loss of coverage due to any of the following:

- Legal separation.
- Divorce.
- Death.
- Ceasing to be a dependent as defined by the terms of a plan.
- Termination of employment.
- Reduction in the number of hours of employment.

It doesn’t include loss of coverage due to failure to timely pay required contributions or premiums, or loss of coverage for cause (for example, you commit fraud or make an intentional misrepresentation of a material fact).

Special enrollment rights also are available if you or your dependents lose other coverage due to any of the following:

- You or one of your dependents incurs a claim that would meet or exceed a lifetime limit on all benefits under the terms of a plan.
- A plan no longer offers any benefits to the class of similarly situated individuals to which you or any of your dependents belong.
- You or one of your dependents who has coverage through an HMO/DHMO no longer resides, lives or works in the HMO/DHMO service area.
You and your dependents must meet certain other requirements as well:

- **Required length of special enrollment:** You and your dependents must request special enrollment in writing no later than 31 days from the day the other coverage was lost.

- **Effective date of coverage:** If you enroll within the 31-day period, coverage takes effect the first day of the month after the other coverage ended.

**Special Enrollment Due to New Dependent Eligibility**

You and your eligible dependents can enroll in the plan (subject to certain conditions) if you acquire a dependent through marriage or formation of a new domestic partnership, birth, adoption or placement for adoption. You and your dependents must request special enrollment in writing no later than 31 days from the date of marriage, the date all of the requirements set forth in the *Chevron Affidavit of Domestic Partnership* are first met, birth, adoption or placement for adoption. The conditions that apply are as follows:

- **Nonenrolled employee:** If you’re eligible but haven’t yet enrolled, you can enroll upon your marriage, upon acquiring a new domestic partner, or upon the birth, adoption or placement for adoption of your child.

- **Nonenrolled spouse/domestic partner:** If you’re already enrolled, you can enroll your spouse/domestic partner at the time of your marriage or acquiring a new domestic partner. You also can enroll your spouse/domestic partner if you acquire a child through birth, adoption or placement for adoption.

- **New dependents of an enrolled employee:** If you’re already enrolled, you can enroll a child who becomes your eligible dependent as a result of your marriage or acquiring a new domestic partner, birth, adoption or placement for adoption.

- **New dependents of a nonenrolled employee:** If you’re eligible but not enrolled, you can enroll an individual (spouse/domestic partner or child) who becomes your dependent as a result of your marriage or acquiring a new domestic partner, birth, adoption or placement for adoption. However, you (the nonenrolled employee) must also be eligible to enroll and actually enroll at the same time.

- **Effective date of coverage:** Coverage takes effect:
  - **Upon marriage:** On the first day of the month coinciding with or following the date of marriage.
  - **Upon formation of a domestic partnership:** On the first day of the month coinciding with or following the date all of the requirements of the *Chevron Affidavit of Domestic Partnership* are first met.
  - **Upon birth:** On the date of the dependent’s birth.
  - **Upon adoption or placement for adoption:** On the date of such adoption or placement for adoption.
  - **When adding a child (other than your own newborn or adopted child) to your coverage:** On the first day of the month coinciding with or following the date the child first becomes your dependent.
Special Enrollment Due to the Children’s Health Insurance Program (CHIP)
The Children’s Health Insurance Program (CHIP) Reauthorization Act of 2009 extends and expands the State Children’s Health Insurance Program (SCHIP). The Act establishes special enrollment rights for employees and their dependents that are eligible for, but not enrolled in coverage under an employer-provided group health plan (such as the Chevron health plans). You and your dependents are eligible to enroll for Chevron health coverage as long as you apply within 60 days of the date that either of the following occurs:

- Medicaid or CHIP coverage is terminated due to loss of eligibility.
- You become eligible for a Medicaid or CHIP premium assistance subsidy. This means that Medicaid or CHIP will subsidize, or pay for, a portion of the Chevron health plan premium cost if you enroll.

If your request for coverage is made within the 60 day period, coverage takes effect:

- The first day of the month after the Medicaid or CHIP coverage ended, or
- The first day of the month following the date you first become eligible for the premium assistance subsidy.

More information, including a listing of states that currently have premium assistance programs, is available in the Other Plan Information chapter, Free or Low-Cost Health Coverage to Children and Families section of this summary plan description.
When Participation Begins

The following charts show when participation begins under the following plans, provided you or your dependents are eligible.

<table>
<thead>
<tr>
<th>Global Choice Plan (U.S.-Payroll Expatriates) (includes prescription drug and basic vision coverage)</th>
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<tbody>
<tr>
<td><strong>Type of Coverage</strong></td>
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<td><strong>Employee Coverage</strong></td>
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<td><strong>Dependent Coverage</strong></td>
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<th>Before-Tax Contribution Plan</th>
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<td><strong>Participation begins:</strong></td>
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<tr>
<td>• Generally at the same time as your participation in any one of the health plans.</td>
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<tr>
<td>• The following January 1, if you enroll in the plan during the open enrollment period.</td>
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</tbody>
</table>
When Participation Ends

Your benefit plan participation will end if any of the following occurs:

- You’re no longer an eligible employee.
- You stop making required contributions.
- Chevron Corporation terminates the plan.

Generally, dependent coverage will end when you're no longer an eligible employee. Your dependents’ participation also will end if they're no longer eligible (for example, you become divorced or a child reaches age 26.

If you commit fraud or make an intentional misrepresentation of a material fact about your participation in the health care plans, the plan has the right to terminate coverage permanently for you and all of your eligible dependents. Also, the plan may seek financial damages caused by the misrepresentations and may pursue legal action against you. Material misrepresentation includes, but is not limited to, adding a dependent who is ineligible (for instance, adding a spouse when you aren't married or adding a child who doesn’t meet the plan qualifications of an eligible dependent).
### A Snapshot of When Coverage Ends
The following chart shows additional rules regarding when coverage ends under each plan.

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<thead>
<tr>
<th>Plan</th>
<th>Participation Ends When:</th>
</tr>
</thead>
</table>
| **Global Choice Plan (U.S.-Payroll Expatriates)** (includes prescription drug and basic vision coverage) | • You or your dependent is no longer eligible. Coverage ends on the last day of the month.  
• You cancel coverage or stop making required contributions. Coverage for you and your dependents ends on the last day of the month for which contributions were received.  
• On the last day of the month in which your resident expatriate assignment ends. You must change to a plan offered where you live within 31 days of losing coverage. New coverage takes effect on the first day of the following month.  
   Coverage for you and your dependents also ends after 31 days of the following types of leave:  
   • Personal Leave Without Pay.  
   • Leave for Educational Reasons.  
   • Long Union Business Leave (unless you elect to pay 100% of the cost of continued coverage).  
   If you or a dependent is hospitalized at the time coverage under the Global Choice Plan (U.S.-Payroll Expatriates) ends, benefits for charges incurred in the hospital can be paid until you or your dependent leaves the hospital. |
| **Before-Tax Contribution Plan**                | • As a result of a qualifying life event, you stop participating in all of the health plans to which Chevron requires you to contribute.  
• You elect to make contributions on an after-tax basis (participation ends on the following December 31).  
• You transfer to a company that doesn’t participate in the Chevron medical plans.  
• You no longer receive a paycheck from Chevron and, as a result, you’re unable to make before-tax contributions.  
• You’re no longer eligible to participate because of a plan change, a change in your employment status or other reasons.  
• The plan is terminated or your employer stops participating in the plan. |

### What Happens if You Die
If you die, your enrolled dependents are eligible for either continuation coverage or retiree and survivor coverage. For more information, see the Retiree and Survivor Coverage section under Continuation Coverage and COBRA Coverage.
How Much You Pay for Coverage

You and Chevron share the cost of your medical plan, which includes the prescription drug coverage (Prescription Drug Program) and basic vision coverage. Your cost for coverage depends on the number of dependents you cover. The cost of coverage is communicated each year during open enrollment. For detailed information about Chevron's contribution policy, see the Company Contributions for Medical Coverage section. For the most up-to-date costs for each plan, you can visit the Benefits Connection website at hr2.chevron.com or contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S).

Your contributions are withheld from your paycheck on a before-tax basis unless you choose to make your contributions on an after-tax basis. At the time you enroll for coverage, you decide if you want your contributions withheld before or after taxes. You can change your election during the open enrollment period.

Chevron Corporation, in its sole discretion, determines the amount that plan members contribute for coverage. In doing this, Chevron Corporation takes into account several factors, including the amount it has agreed to pay toward coverage and the expected cost of claims and expenses. If the payment of claims and expenses exceeds contributions from plan members and Chevron, Chevron Corporation will make up the difference. However, this deficit would then be considered when Chevron Corporation determines future contribution rates for plan members.
Medical Coverage

This section provides a description of the medical coverage under the Global Choice Plan (U.S.-Payroll Expatriates) for you and your eligible dependents.

- Medical Services Outside the U.S. – Cigna
- Medical Services Inside the U.S. – Cigna

To see information about prescription drug coverage, go to the Prescription Drug Coverage section starting on page 41. To see information about basic vision coverage, go to the Vision Coverage section starting on page 78.
Medical Coverage Introduction

If you are a U.S.-payroll expatriate and an eligible employee as described under the Eligibility and Participation section of this SPD, then you are eligible to participate in the Chevron Corporation Global Choice Plan (U.S.-Payroll Expatriates) hereafter referred to as Global Choice Plan. Your only option for Chevron-sponsored medical coverage is the Global Choice Plan.

The Global Choice Plan provides health care benefits to eligible U.S.-payroll expatriates who enroll in the plan. Health care benefits provided under the Global Choice Plan include:

- Medical benefits obtained inside the U.S. (Cigna).
- Medical benefits obtained outside the U.S. (Cigna).
- Prescription drugs obtained outside the U.S. (Cigna).

In addition, if you enroll in the Global Choice Plan, you are also automatically enrolled in:

- The Chevron Prescription Drug Program (Express Scripts) for prescription drugs obtained inside the U.S.
- The Chevron Vision Program (VSP Vision Care) for basic vision benefits.

This section discusses medical coverage only. For more information about prescription drugs and vision, see the corresponding sections in this SPD.
Review the Cigna Certificate of Coverage

Cigna insures the medical benefits provided by the Global Choice Plan. The benefits provided by the Global Choice Plan are governed by the insurance contracts with Cigna and are described in the Certificate of Coverage. The Certificate of Coverage describes the Global Choice Plan’s benefits as they pertain to medical benefits both inside and outside the U.S. and prescription drugs obtained outside the U.S., such as:

- Covered treatment.
- Covered services.
- Exclusions and limitations.
- Deductibles, benefit maximums and out-of-pocket maximums.
- Procedural requirements (such as preauthorization, filing claims, obtaining care).

You should carefully review the Certificate of Coverage before obtaining services to verify what is covered and make sure you comply with any preauthorization requirements. For a copy of the Certificate of Coverage you can:

- Print one from www.cignaenvoy.com
- Go to hr2.chevron.com on the Internet. To get started, choose the option that applies to you from the Benefits Information dropdown in the main banner.

How to Contact Cigna

Customer Service

- Toll free: 1-800-828-5822
- Direct (collect calls accepted): 001-302-797-3871
- Toll-free facsimile number: 001-302-797-3150
- www.cignaenvoy.com

Where to send claims for care received in the U.S.
Cigna
P.O. Box 15050
Wilmington, DE 19850-5050

Mail Delivery
Cigna
P.O. Box 15050
Wilmington, DE 19850-5050

Courier Delivery
Cigna
300 Bellevue Parkway
Wilmington, DE 19809
Keep in Mind …

Cigna insures the health benefits provided under the Global Choice Plan. This means:

- Cigna administers benefits for medical services obtained inside the U.S.; medical services obtained outside the U.S.; prescription drugs obtained outside the U.S. only.

- There is a deductible under the Global Choice Plan that applies to medical benefits inside the U.S., medical benefits outside the U.S. and prescription drugs obtained outside the U.S., combined.

- There is an out-of-pocket maximum under the Global Choice Plan that applies to medical benefits inside the U.S., medical benefits outside the U.S. and prescription drugs obtained outside the U.S. combined.

- If you receive medical services in the U.S., there are different levels of benefits for network providers and non-network providers. Higher benefits are paid when you receive health care services from a network provider in the U.S. You always have the option of using an out-of-network provider, but plan benefits are lower if you do. Contact Cigna for a list of network providers in the U.S.

- Cigna uses CignaLinks in countries where it’s available: Africa (South Africa, Tanzania, Kenya, Morocco, Egypt, and Nigeria); Australia; Brazil; China; Hong Kong; Indonesia; Macau; Malaysia; the Middle East (Saudi Arabia, United Arab Emirates, Kuwait, Bahrain, Oman, and Qatar); Singapore; Spain; Taiwan; the United Kingdom.

- The following CignaLinks countries require a separate ID card when accessing services. The additional ID card will be issued automatically if applicable in your situation.
  - Spain
  - Middle East
  - Australia
  - Africa
  - Brazil

Cigna does not administer vision benefits or benefits for prescription drugs obtained inside the U.S. While you are automatically enrolled in these benefits when you enroll in the Global Choice Plan, they are administered under separate programs. See the corresponding sections of this SPD for further explanation of these benefits.
How to File a Medical Claim with Cigna

This section briefly describes how to file a claim for medical services (inside and outside the U.S.) and prescription drugs (inpatient and outpatient obtained outside the U.S.) that you believe are covered by the Global Choice Plan. Note that you must file a claim for payment of plan benefits no later than six months (by June 30) following the calendar year in which the service was provided. If you don’t file a proper claim with Cigna within this time frame, benefits for that health service will be denied. You should be aware that Cigna has the right to request repayment if they overpay a claim for any reason. Additional details and instructions are provided in the Certificate of Coverage.

Where to Get a Claim Form

- HR2 website at hr2.chevron.com. To get started, choose the option that applies to you from the Benefits Information dropdown in the main banner.

Claims for U.S. Services

If you go to a network provider for care, your provider files the claim for you. If you go to an out-of-network provider for care, you usually have to pay for the service and file a claim to be reimbursed. You should file a medical claim as soon as you incur a covered charge, even if you haven’t yet paid your deductible. When you receive services from an out-of-network provider, you are responsible for requesting payment from Cigna.

You are strongly encouraged to submit your claims online at www.cignaenvoy.com. It’s the fastest and easiest way to obtain reimbursement.

Where to send claims for care received in the U.S.

Cigna
P.O. Box 15050
Wilmington, DE 19850-5050

**Mail Delivery**

Cigna
P.O. Box 15050
Wilmington, DE 19850-5050

**Courier Delivery**

Cigna
300 Bellevue Parkway
Wilmington, DE 19809
Claims for Services Outside the U.S.
If you go to a provider outside the U.S. for care, you usually have to pay full price for the service and file a claim to request reimbursement for covered charges. You should file a medical claim as soon as you incur a covered charge. You are responsible for requesting payment from Cigna.

You are strongly encouraged to submit your claims online at www.cignaenvoy.com. It’s the fastest and easiest way to obtain reimbursement.

Where to send claims for care received outside the U.S.

Mail Delivery
Cigna
P.O. Box 15050
Wilmington, DE 19850-5050

Courier Delivery
Cigna
300 Bellevue Parkway
Wilmington, DE 19809
Medical Claim Reviews and Appeals with Cigna

The Global Choice Plan has a claim review process that is followed whenever you submit a claim for benefits. The sections below briefly describe this process for claims for medical services (inside and outside the U.S.) and prescription drugs (inpatient and outpatient obtained outside the U.S.) that you believe are covered by the Global Choice Plan. If your dispute concerns eligibility to participate in the plan, you must follow the procedures described in the How to File a Claim for Eligibility section of this summary plan description.

Initial Review and Decision
When you file a claim, the claims administrator (Cigna or its delegate) reviews the claim and makes a decision to either approve or deny the claim (in whole or in part). You will receive a written notice of the claim decision within the time limits described in the chart that follows. Those time limits are based on the type of claim and whether you submit a proper claim, including all necessary information.

Types of Claims
There are generally three types of claims with respect to an ERISA group health plan:

- **Urgent care claim**: Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or which, in the opinion of your doctor, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

- **Pre-service claim**: Any claim for a benefit with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on your obtaining approval before you receive such medical services.

- **Post-service claim**: Any claim that is not a pre-service claim — that is, does not require approval and is filed for payment of benefits after medical care has been received.

Another type of claim is the concurrent care claim. For more information, see Concurrent Care Claims in this section.

Time Limits for Processing Claims
The claims administrator must follow certain time limits when processing claims for plan benefits:

- **Plan notice of improper or incomplete claim**: If you filed the claim improperly, or if additional information is needed to process the claim, you will receive a notice describing how to properly file the claim or describing the additional information needed.

- **Your deadline to complete the claim**: If you receive a notice from the plan that your claim is incomplete, you then have a deadline to complete the claim.

- **Plan notice of initial claim decision**: Once the plan receives a proper claim, the plan has a deadline to notify you of its decision.
### Time Limits for Processing Claims

*This chart describes the time limits for processing different types of claims.*

<table>
<thead>
<tr>
<th>Time Limits</th>
<th>Urgent Care Health Claims</th>
<th>Preservice Health Claims</th>
<th>Postservice Health Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Plan notice of failure to follow the proper claim procedures</em></td>
<td>Not later than 24 hours after receiving the improper claim.</td>
<td>Not later than 5 days after receiving the improper claim.</td>
<td>N/A</td>
</tr>
<tr>
<td><em>Your deadline to provide additional information required by the plan to decide your claim</em></td>
<td>48 hours after receiving notice that additional information is required.</td>
<td>45 days after receiving notice that additional information is required.</td>
<td>45 days after receiving notice that additional information is required.</td>
</tr>
<tr>
<td><em>Plan notice of initial claim decision</em></td>
<td>1. Not later than 72 hours after receiving the initial claim, if it was proper and complete.</td>
<td>1. Not later than 15 days after receiving the initial claim, unless an extension, up to 15 days, is necessary due to matters beyond the control of the plan. The maximum time period is 30 days total. You will be notified within the initial 15 days if an extension is needed.</td>
<td>1. Not later than 30 days after receiving the initial claim, unless an extension, up to 15 days, is necessary due to matters beyond the control of the plan. The maximum time period is 45 days total. You will be notified within the initial 30 days if an extension is needed.</td>
</tr>
<tr>
<td></td>
<td>2. Not later than 48 hours after receiving additional information or after the expiration of your 48-hour deadline to provide such information to complete the claim, whichever is earlier.</td>
<td>2. Not later than 15 days after receiving the initial claim, unless you need to provide additional information. You will be notified during the initial 15-day period and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving your additional information or after the expiration of your 45-day deadline to complete the claim, whichever is earlier.</td>
<td>2. Not later than 30 days after receiving the initial claim, unless you need to provide additional information. You will be notified during the initial 30-day period, and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving your additional information or after the expiration of your 45-day deadline to complete the claim, whichever is earlier.</td>
</tr>
</tbody>
</table>
Concurrent Care Claims
If an ongoing course of treatment was previously approved for a specific period of time or number of
treatments and your request to extend the treatment is an urgent care claim as defined under Types of
Claims in this section, your request will be decided within 24 hours, provided your request is made at least
24 hours prior to the end of the approved treatment. The claims administrator will make a determination on
your request for the extended treatment within 24 hours from receipt of your request. If your request for
extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request
will be treated as an urgent care claim and decided according to the time limits described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of
treatments and you request to extend treatment in a nonurgent circumstance, your request will be
considered a new claim and decided according to preservice or postservice time limits, whichever applies.

If an ongoing course of treatment was previously approved for a specific period of time or number
of treatments and there is a reduction or termination of the course of treatment (other than by plan
amendment or termination) before the end of the period of time or number of treatments, the plan will notify
you. This will be considered a denied claim. The notification will be sufficiently in advance of the reduction
or termination to allow you to appeal the denial and receive a determination on appeal before the reduction
or termination of the benefits. If you decide to appeal, you must follow the applicable appeals procedure
described in If Your Claim Is Denied (for claims other than for outpatient prescription drugs and vision
coverage) in this section.

Notice and Payment of Claims
The claims administrator will make a benefit determination on behalf of the plan and according to the plan’s
provisions. You’ll receive a notice within the time limits described in the chart (see Plan notice of initial
claim decision) under Initial Review and Decision in this section.

Please note that for an urgent care claim, you will receive notice (whether adverse or not) in writing or
electronically. This notice also may be given orally, with a written or electronic confirmation to follow within
three days.

If your claim is approved, benefits will be paid to you unless the provider notifies the claims
administrator that your signature is on file, assigning benefits directly to that provider. The claims
administrator will not reimburse third parties who have purchased or have been assigned benefits
by doctors or other providers.

If your claim is denied, there is an additional procedure for appealing a denied decision.

You should also be aware that the claims administrators have the right to request repayment if they
overpay a claim for any reason.
If Your Claim Is Denied
If your claim is denied (in whole or in part), you will receive a written notice that includes the following:

- Information sufficient to identify the claim involved.

- The reason(s) for the denial and the specific plan provision(s) upon which the denial was based.

- A description of any additional material or information that’s needed to complete the claim and an explanation of why such material or information is needed.

- An explanation of the plan’s appeals procedures and the time limits that apply to them (including a statement of your right to file a civil lawsuit under Section 502(a) of ERISA following an adverse determination after completion of all levels of appeal/review required by the plan).

- Any additional information required by Department of Labor claim, appeal, and external review regulations.

Sometimes a claim is denied based on an internal rule, guideline, protocol or other similar item. If this happens, the notice will include a copy of the rule, guideline, protocol or item that was relied on to deny the claim. Alternatively, the notice will include a statement that an internal rule, guideline, protocol or similar item was relied on to deny your claim, and you can request a copy of it (the rule, guideline, protocol or other similar item) free of charge.

If your claim for benefits is denied based on medical necessity or experimental treatment or a similar exclusion or limit, the notice must include an explanation of the scientific or clinical judgment for the determination. It also must apply the terms of the plan to your medical circumstances. Alternatively, the notice will include a statement that such explanation will be provided to you free of charge upon request.

Before You Appeal
Before you officially appeal a denial of a claim, you can call the claims administrator to see if a resolution is possible. For example, the claims administrator may need more information to process your claim. However, if no further information is needed or if you aren’t satisfied with the explanation of why the claim was denied, you can request, in writing, to have the claim reviewed.

The claims administrator processes payments for claims, answers questions and reviews appeals according to the plan’s provisions.
How to File an Appeal
This section describes how to file an appeal with Cigna and the time limits that apply to the different types of medical appeals.

<table>
<thead>
<tr>
<th>Time Limits</th>
<th>Urgent Care Health Claims</th>
<th>Preservice Health Claims</th>
<th>Postservice Health Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your deadline to file a first appeal</td>
<td>180 days after receiving the claim denial notice.</td>
<td>180 days after receiving the claim denial notice.</td>
<td>180 days after receiving the claim denial notice.</td>
</tr>
<tr>
<td>Plan notice of first appeal decision</td>
<td>Not later than 24 hours after receiving an appeal.</td>
<td>Not later than 15 days after receiving an appeal.</td>
<td>Not later than 30 days after receiving an appeal.</td>
</tr>
<tr>
<td>Your deadline to file a second appeal</td>
<td>Not applicable.</td>
<td>90 days after receiving the first appeal denial notice.</td>
<td>90 days after receiving the first appeal denial notice.</td>
</tr>
<tr>
<td>Plan notice of second appeal decision</td>
<td>Not applicable.</td>
<td>Not later than 15 days after receiving a second appeal.</td>
<td>Not later than 30 days after receiving a second appeal.</td>
</tr>
<tr>
<td>Your deadline to request an External Review</td>
<td>4 months after receiving the appeal denial notice.</td>
<td>4 months after receiving the second appeal denial notice</td>
<td>4 months after receiving the second appeal denial notice.</td>
</tr>
<tr>
<td>IRO notice of External Review Decision</td>
<td>Not later than 72 hours after receiving the request.</td>
<td>Not later than 45 days after receiving the request for external review.</td>
<td>Not later than 45 days after receiving the request for external review.</td>
</tr>
</tbody>
</table>

First Appeal
After receiving the notice of denial, you or your authorized representative (this can be your provider, your beneficiary, your legal representative or another appropriately authorized individual) may ask for an appeal, which is a full and fair review of the initial claim decision, by writing to the claims administrator. You must make this request for an appeal in writing within the time limits noted in the chart above.

During the time limit for requesting an appeal, upon request and free of charge, you or your authorized representative will be given reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits. You may also request to review the claim file.
Your appeal should include all of the following:

- Patient’s name and the identification number from the ID card.
- Date(s) of medical service(s).
- Provider’s name.
- Explanation of why you believe the claim should be paid.

You also can submit to the claims administrator any written comments, documents, records and other information or testimony relating to your claim for benefits.

For an urgent care claim, information may be provided by phone or fax.

Send your appeal to:

**Mail Delivery**
Cigna
P.O. Box 15050
Wilmington, DE 19850-5050

**Courier Delivery**
Cigna
300 Bellevue Parkway
Wilmington, DE 19809

**Time Limits and Procedures for Processing Your First Appeal**

Upon receipt of your appeal, the claims administrator will review the claim again and will make a decision based on all comments, documents, records and other information you've submitted, without regard to whether such information was submitted or considered in the initial benefit determination. This review will be completed within the time limits shown in the chart under Time Limits for Processing Appeals under How to File an Appeal in this section.

As part of the appeals procedure, these steps are followed:

- The review on appeal will not afford deference to the initial denial, and it will be conducted by a fiduciary who is neither the individual who initially denied the claim that is the subject of the appeal nor the subordinate of such individual.

- If your claim is denied based in whole or in part on a medical judgment — including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate — the fiduciary reviewing the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

- The health care professional consulted by the fiduciary reviewing the appeal will be an individual who is neither an individual who was consulted in connection with the denial of the claim that is the subject of the appeal nor the subordinate of such individual.
• Upon your request, the claims administrator will identify any medical or vocational experts whose advice was obtained on behalf of the plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

• If the claims administrator considers, relies upon, or generates any additional or new evidence during the appeal or if the claims administrator will base an impending denial upon any new or additional rationale, the claims administrator will provide such evidence or rationale as soon as possible in advance of the date the decision is due in order to give you a reasonable opportunity to respond prior to the decision being issued.

Notice of Decision on First Appeal
If, on the appeal, the claims administrator determines that your explanation and additional information support the payment of your claim, the claims administrator will process your claim. Benefits are paid to you unless the provider notifies the claims administrator that your signature is on file, assigning benefits directly to that provider.

If your first appeal is denied (in whole or in part), you will receive a written notice. The notice will contain information sufficient to identify the claim involved. The notice will state the reasons for the denial, including references to specific plan provisions upon which the denial was based and a statement of your right to file a civil lawsuit under Section 502(a) of ERISA following an adverse determination after completion of all levels of appeal/review required by the plan.

The notice will state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

If your appeal is denied based on an internal rule, guideline, protocol or other similar item, the notice will include a copy of the rule, guideline, protocol or item that was relied on to deny the claim. Alternatively, the notice will include a statement that an internal rule, guideline, protocol or similar item was relied on to deny your claim, and you can request a copy of it (the rule, guideline, protocol or other similar item) free of charge.

If your appeal is denied based on medical necessity or experimental treatment or a similar exclusion or limit, the notice must include an explanation of the scientific or clinical judgment for the determination. It also must apply the terms of the plan to your medical circumstances. Alternatively, the notice will include a statement that such explanation will be provided to you free of charge upon request.

The notice will include any additional information required by Department of Labor claim, appeal, and external review regulations.

If, on the appeal, the claims administrator upholds the denial of your claim, you may file a second appeal in accordance with Section 7.5 of the Certificate of Coverage. If, upon the second appeal, the claims administrator upholds the denial of your claim, you may file a request for an external review by contacting Cigna. In certain urgent cases, you may request an expedited external review. Contact Cigna for more information.
Customer Service

- Toll free: 1-800-828-5822
- Direct (collect calls accepted): 001-302-797-3871
- Toll-free facsimile number: 001-302-797-3150
- www.cignaenvoy.com

Mail Delivery
Cigna
P.O. Box 15050
Wilmington, DE 19850-5050

Courier Delivery
Cigna
300 Bellevue Parkway
Wilmington, DE 19809

Second Appeal
Under the Global Choice Plan, you are allowed two levels of appeal (except for urgent care claims). After receiving the notice of denial of your first appeal, you or your authorized representative (this can be your provider, your beneficiary, your legal representative or another appropriately authorized individual) may ask for a second appeal. You must make this request for a second appeal in writing within the time limits noted in the chart above, Time Limits for Processing Appeals, in the Time Limits for Processing Medical Benefit Appeals section. The second appeal should also include any additional information that wasn’t previously submitted with your first appeal, as well as an explanation supporting your position.

Time Limits and Procedures for Processing Your Second Appeal
Upon receipt of your second appeal, the claims administrator reviews the claim again and makes a decision based on all comments, documents, records and other information you’ve submitted, without regard to whether such information was submitted or considered in the initial benefit determination.

This second appeal will be completed within the time limits shown in the chart above, Time Limits for Processing Appeals.

The second appeal will follow the same procedural steps as described for the first appeal. If the claims administrator considers, relies upon, or generates any additional or new evidence during the appeal or if the claims administrator will base an impending denial upon any new or additional rationale, the claims administrator will provide such evidence or rationale as soon as possible in advance of the date the decision is due in order to give you a reasonable opportunity to respond prior to the decision being issued.

Notice of Decision on Second Appeal
If, on second appeal, the claims administrator’s doctor or specialist determines that your explanation and additional information support the payment of your claim, the claims administrator will process your claim. Benefits are paid to you unless the provider notifies the claims administrator that your signature is on file, assigning benefits directly to that provider.

If your second appeal is denied (in whole or in part), you will receive a written notice. The notice will contain information sufficient to identify the claim involved. The notice will state the reasons for the denial, including references to specific plan provisions upon which the denial was based and a statement of your right to file a civil lawsuit under Section 502(a) of ERISA after all levels of required appeal/review have been exhausted. The notice will explain how to request an external review.
The notice will state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

If your second appeal is denied based on an internal rule, guideline, protocol or other similar item, the notice will include a copy of the rule, guideline, protocol or item that was relied on to deny the claim. Alternatively, the notice will include a statement that an internal rule, guideline, protocol or similar item was relied on to deny your claim, and you can request a copy of it (the rule, guideline, protocol or other similar item) free of charge.

If your second appeal is denied based on medical necessity or experimental treatment or a similar exclusion or limit, the notice must include an explanation of the scientific or clinical judgment for the determination. It also must apply the terms of the plan to your medical circumstances. Alternatively, the notice will include a statement that such explanation will be provided to you free of charge upon request.

The claims administrator is the named fiduciary that serves as the final review committee and, in its sole discretion, has the authority to interpret plan provisions, as well as facts and other information related to claims and appeals.

**Requesting an External Review**

If your second appeal is denied, you may have the right to request an external review. An external review will be provided only when the claim denial involved medical judgment (for example, a denial based on the plan’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit or a determination that a treatment is experimental or investigational) or the matter is a rescission of coverage.

A de minimis (small) deviation from strict adherence to the internal claims and appeals procedure on the part of the relevant claims administrator or review panel that does not cause, or is not likely to cause, prejudice or harm to the claimant will not waive the requirement to exhaust the internal claims and review procedure before obtaining an external review or filing a lawsuit. The claims administrator shall provide an explanation of such deviation within 10 days of the request of the claimant. If a request for external review is denied on account of the failure to exhaust the internal claims and appeals process when a de minimis deviation is involved, the claimant shall have the right to pursue the internal process.

You or your authorized representative can request an external review in writing or verbally to the claims administrator by following the instructions in your denial notice or writing to the claims administrator at the address listed in the Administrative Information section. The claims administrator will provide an external review procedure through an accredited Independent Review Organization (IRO) after determining the following:

- You were covered under the plan at the time the services were provided.
- The claim denial is not a result of failure to meet the requirements for eligibility under the plan.
- You have exhausted the appeal process described above.

The IRO will conduct an external review of an adverse benefit determination and issue a final external review decision. The claims administrator will provide case information to the IRO and notify you of the name and contact information for the IRO reviewing your request for external review. The IRO will communicate their external review decision to you and the claims administrator. If the IRO determines that your explanation and additional information support the payment of your claim, the claims administrator will immediately provide coverage or payment of the claim. If your external review is denied, you will receive a written notice from the IRO.
Expedited External Review
You may request an expedited external review if any of the following apply:

- Your urgent care appeal is denied.
- The denial of your claim or appeal involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function.
- You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or if the final internal decision on review concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

To request an expedited external review, contact:

Customer Service
- Toll free: 1-800-828-5822
- Direct (collect calls accepted): 001-302-797-3871
- Toll-free facsimile number: 001-302-797-3150
- www.cignaenvoy.com

Mail Delivery
Cigna
P.O. Box 15050
Wilmington, DE 19850-5050

Courier Delivery
Cigna
300 Bellevue Parkway
Wilmington, DE 19809

Administrative Power and Responsibilities
Chevron Corporation has the discretionary authority to control and manage the administration and operation of the Omnibus Health Care Plan (the Plan). Chevron Corporation shall have the full, exclusive and discretionary authority to prescribe such forms; make such rules, regulations, interpretations and computations; construe the terms of the Plan; determine all issues relating to coverage and eligibility for benefits; and take such other action to administer the Plan as it may deem appropriate in its sole discretion. Chevron Corporation’s rules, regulations, interpretations, computations and actions shall be final and binding on all persons. Such discretionary authority can also be exercised by a delegate. The insurer has discretionary authority to act with respect to any appeal for a denial of benefits under the Global Choice Plan.
If You’re Covered by More Than One Health Plan

Coordination of benefits is a feature used to determine how much the Global Choice Plan pays when you or one of your dependents is covered by more than one group medical plan. This feature is designed to prevent overpayment of benefits. This section does not apply to the basic vision coverage under the Global Choice Plan (U.S.-Payroll Expatriates).

How It Works
Under the coordination of benefits rules, one plan pays benefits first (the primary payer) and one plan pays second (the secondary payer). (See below and the following page for explanations of primary payer and secondary payer.) The primary payer pays the benefits provided by its plan features. The secondary payer then pays any excess amounts required to bring the total benefits paid up to the levels payable under its plan. The sum of the benefits paid from each plan will not exceed the actual expense incurred. If the Chevron health plan is the secondary payer, the combined benefit from both plans won’t be more than the Chevron plan’s limit for the covered charges (except for the Dental PPO Plan and the Prescription Drug Program). Different coordination of benefits rules apply under different circumstances.

Note: Coordination of benefits does not apply to benefits payable under any private accident or health insurance plans. Also, it does not apply to benefits payable under any other group insurance or health care plan maintained by Chevron. However, the plans do coordinate benefits with the Dental Plan in case of accidental injury to teeth.

If You or a Dependent Is Covered by More Than One Plan
A plan other than your Global Choice Plan will be the primary payer if any of the following conditions applies to the other plan:

- It doesn’t have a coordination of benefits rule.
- It covers the individual as an eligible employee or retiree (while your Global Choice Plan covers the individual as a dependent).
- It covers the individual as an employee (while your Global Choice Plan covers the individual as an eligible retiree).
- It has covered the individual longer than your Global Choice Plan (if the other conditions in this bulleted list don’t apply).
- It’s the Chevron Dental Plan.

If your Global Choice Plan is the secondary payer, the combined benefit from both plans won’t total more than your Global Choice Plan’s limit for the covered charges. Here’s an example of how this works.

Suppose a Chevron employee covers her husband as a dependent under the Global Choice Plan. Her husband is also covered by his company’s medical plan. Under the coordination of benefits provisions, the husband’s plan pays first when he has medical expenses (the primary plan). The Global Choice Plan pays the remaining covered charges, if any, up to plan limits after the deductible. For example, assume the husband has surgery that requires a three-day hospital stay, the total cost for his surgery is $10,000, all of these charges are covered under the Global Choice Plan (U.S.-Payroll Expatriates) and he has already met the $300 deductible. Having used a network provider and hospital under the Global Choice Plan (U.S.-
Payroll Expatriates), he is eligible for a 90 percent reimbursement (or $9,000). But the primary plan pays $8,000, so the Global Choice Plan (U.S.-Payroll Expatriates) pays only $1,000.

**Note:** Coordination of benefits does not apply to benefits payable under any private accident or health insurance plans. Also, it does not apply to benefits payable under any other group insurance or health care plan maintained by Chevron. However, the plan does coordinate benefits with the Dental Plan in case of accidental injury to teeth.

**Coordinating Your Children’s Coverage With Your Spouse's/Domestic Partner's Plan**

If you’re covered by the Global Choice Plan and your spouse/domestic partner is covered by another group plan (and the other group health plan has a coordination of benefits rule), special rules apply to dependent children covered under both plans:

- In the case of domestic partnerships, the medical plan of the natural parent is the primary payer.
- In the case of a married couple, the medical plan of the parent whose birthday falls earlier in the calendar year is the primary payer.
- If both parents have the same birthday, the plan that covered a parent longer is the primary payer.
- If the other plan does not have a birthday rule, the plan of the male is the primary payer.
- If the other plan does not have a birthday rule but instead has a rule based on the gender of the parent, and if as a result the plans do not agree on the order of benefits, the rule in the other plan determines the order of benefits.

**Note:** Coordination of benefits does not apply to benefits payable under any private accident or health insurance plans. Also, it does not apply to benefits payable under any other group insurance or health care plan maintained by Chevron. However, the plan does coordinate benefits with the Dental Plan in case of accidental injury to teeth.

**Your Children’s Coverage if You’re Divorced or Separated**

When parents are separated or divorced or living apart due to termination of a domestic partnership, and children are covered under more than one health care plan and there is no court order to the contrary, the following rules apply:

- The plan of the parent with custody of (or court-ordered financial responsibility for) the child is the primary payer.
- The plan of the spouse of the parent or domestic partner of the parent with custody of the child is the secondary payer.
- The plan of the parent or domestic partner without custody (or court-ordered financial responsibility) pays last.

**Note:** Coordination of benefits does not apply to benefits payable under any private accident or health insurance plans. Also, it does not apply to benefits payable under any other group insurance or medical plan maintained by Chevron. However, the plan does coordinate benefits with the Dental Plan in case of accidental injury to teeth.
Prescription
Drug Coverage

This section provides a description of the prescription drug coverage under the Global Choice Plan (U.S.-Payroll Expatriates) for you and your eligible dependents.

- Prescription Drugs Obtained Outside the U.S.
  Global Choice Plan - Cigna
- Prescription Drugs Obtained Inside the U.S.
  Prescription Drug Program – Express Scripts

To see information about medical coverage, go to the Medical Coverage section starting on page 23. To see information about basic vision coverage, go to the Vision Coverage section starting on page 78.
Prescription Drug Introduction

This section provides a description of the prescription drug coverage under the Global Choice Plan (U.S.-Payroll Expatriates) for you and your eligible dependents. When you enroll in the Global Choice Plan, prescription drug benefits for prescriptions obtained outside and inside the U.S. are automatically included in your coverage. However, prescriptions obtained inside the U.S. and prescriptions obtained outside the U.S. are administered under separate plans and programs. This means there is a separate deductible, out-of-pocket maximum and plan provisions depending where the prescriptions were obtained.

If you enroll in the Global Choice Plan, your coverage also automatically includes prescription drug coverage as follows:

- A benefit for prescription drugs obtained outside the U.S. (Cigna – Global Choice Plan)
- A benefit for prescription drugs obtained inside the U.S. (Express Scripts – Chevron Prescription Drug Program)

This section only discusses prescription drug coverage. For more information about medical and vision coverage see the corresponding sections in this SPD.
Prescription Drugs
Obtained OUTSIDE the U.S.
Global Choice Plan - Cigna
Review the Cigna Certificate of Coverage

Cigna insures the health care benefits provided by the Global Choice Plan, which includes inpatient prescription drugs and outpatient prescription drugs obtained outside the U.S. If you enroll in the Global Choice Plan, your benefit also automatically includes this prescription drug coverage. The health care benefits provided by the Global Choice Plan are governed by the insurance contracts with Cigna and are described in the Certificate of Coverage. The Certificate of Coverage describes the Global Choice Plan’s benefits as they pertain to prescription drugs obtained outside the U.S., such as:

- Covered services.
- Exclusions and limitations.
- Deductibles, benefit maximums and out-of-pocket maximums.
- Procedural requirements (such as preauthorization, filing claims, obtaining prescription drugs).

You should carefully review the Certificate of Coverage before obtaining services to verify what is covered and make sure you comply with any requirements. The Certificate of Coverage is available online at hr2.chevron.com on the Internet. To get started, choose the option that applies to you from the Benefits Information dropdown in the main banner. You can also request a copy:

Customer Service
- Toll free: 1-800-828-5822
- Direct (collect calls accepted): 001-302-797-3871
- Toll-free facsimile number: 001-302-797-3150
- www.cignaenvoy.com

Mail Delivery
Cigna
P.O. Box 15050
Wilmington, DE 19850-5050

Courier Delivery
Cigna
300 Bellevue Parkway
Wilmington, DE 19809
How to File a Prescription Drug Claim with Cigna

This section briefly describes how to file a claim for prescription drugs obtained outside the U.S. that you believe are eligible for reimbursement under the Global Choice Plan. For prescriptions filled inside the U.S., see the Prescription Drugs Obtained Inside the U.S. section.

When you obtain prescription drugs outside the U.S., you usually have to pay in full for the medication and file a claim to request reimbursement of covered charges. You should file a claim for services as soon as you incur a covered charge. (If you are using a U.S. network provider, you generally do not need to file a claim). You are responsible for requesting payment from Cigna. Note that you must file a claim for payment of plan benefits no later than six months (by June 30) following the calendar year in which the service was provided. If you don’t file a proper claim with the claims administrator within this time frame, benefits for that health service will be denied. You should be aware that Cigna has the right to request repayment if they overpay a claim for any reason. Additional details and instructions are provided in the Certificate of Coverage.

Where to Get a Claim Form

When filing claims for prescription drugs obtained outside the U.S., you will use the same claim form used for medical services.

- HR2 website at hr2.chevron.com. To get started, choose the option that applies to you from the Benefits Information dropdown in the main banner.

Customer Service

- Toll free: 1-800-828-5822
- Direct (collect calls accepted): 001-302-797-3871
- Toll-free facsimile number: 001-302-797-3150
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How to Contact Cigna

Customer Service

- Toll free: 1-800-828-5822
- Direct (collect calls accepted): 001-302-797-3871
- Toll-free facsimile number: 001-302-797-3150
- www.cignaenvoy.com
Prescription Drug Claims Review and Appeals with Cigna

The Global Choice Plan has a claim review process that is followed whenever you submit a claim for benefits. The sections below briefly describe this process for filing health care claims that you believe are eligible for reimbursement under the Global Choice Plan. If your dispute concerns eligibility to participate in the plan, you must follow the procedures described in the How to File a Claim for Eligibility section of this summary plan description.

Initial Review and Decision
When you file a claim, the claims administrator (Cigna or its delegate) reviews the claim and makes a decision to either approve or deny the claim (in whole or in part). You will receive a written notice of the claim decision within the time limits described in the chart that follows. Those time limits are based on the type of claim and whether you submit a proper claim, including all necessary information.

Types of Claims
There are generally three types of claims with respect to an ERISA group health plan:

- **Urgent care claim:** Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or which, in the opinion of your doctor, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

- **Pre-service claim:** Any claim for a benefit with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on your obtaining approval before you receive such medical services.

- **Post-service claim:** Any claim that is not a pre-service claim — that is, does not require approval — and that is filed for payment of benefits after medical care has been received.

Another type of claim is the concurrent care claim. For more information, see Concurrent Care Claims in this section.

Time Limits for Processing Claims
The claims administrator must follow certain time limits when processing claims for plan benefits:

- **Plan notice of improper or incomplete claim:** If you filed the claim improperly, or if additional information is needed to process the claim, you will receive a notice describing how to properly file the claim or describing the additional information needed.

- **Your deadline to complete the claim:** If you receive a notice from the plan that your claim is incomplete, you then have a deadline to complete the claim.

- **Plan notice of initial claim decision:** Once the plan receives a proper claim, the plan has a deadline to notify you of its decision.
### Time Limits for Processing Claims

*This chart describes the time limits for processing different types of claims.*

<table>
<thead>
<tr>
<th>Time Limits</th>
<th>Urgent Care Health Claims</th>
<th>Preservice Health Claims</th>
<th>Postservice Health Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan notice of failure to follow the proper claim procedures</strong></td>
<td>Not later than 24 hours after receiving the improper claim.</td>
<td>Not later than five days after receiving the improper claim.</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Your deadline to provide additional information required by the plan to decide your claim</strong></td>
<td>48 hours after receiving notice that additional information is required.</td>
<td>45 days after receiving notice that additional information is required.</td>
<td>45 days after receiving notice that additional information is required.</td>
</tr>
<tr>
<td><strong>Plan notice of initial claim decision</strong></td>
<td>1. Not later than 72 hours after receiving the initial claim, if it was proper and complete.</td>
<td>1. Not later than 15 days after receiving the initial claim, unless an extension, up to 15 days, is necessary due to matters beyond the control of the plan. The maximum time period is 45 days total. You will be notified within the initial 15 days if an extension is needed.</td>
<td>1. Not later than 30 days after receiving the initial claim, unless an extension, up to 15 days, is necessary due to matters beyond the control of the plan. The maximum time period is 45 days total. You will be notified within the initial 30 days if an extension is needed.</td>
</tr>
<tr>
<td></td>
<td>2. Not later than 48 hours after receiving additional information or after the expiration of your 48-hour deadline to provide such information to complete the claim, whichever is earlier.</td>
<td>2. Not later than 15 days after receiving the initial claim, unless you need to provide additional information. You will be notified during the initial 15-day period and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving your additional information or after the expiration of your 45-day deadline to complete the claim, whichever is earlier.</td>
<td>2. Not later than 30 days after receiving the initial claim, unless you need to provide additional information. You will be notified during the initial 30-day period and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving your additional information or after the expiration of your 45-day deadline to complete the claim, whichever is earlier.</td>
</tr>
</tbody>
</table>
**Concurrent Care Claims**

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and your request to extend the treatment is an urgent care claim as defined under Types of Claims in this section, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The claims administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the time limits described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and you request to extend treatment in a nonurgent circumstance, your request will be considered a new claim and decided according to preservice or postservice time limits, whichever applies.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and there is a reduction or termination of the course of treatment (other than by plan amendment or termination) before the end of the period of time or number of treatments, the plan will notify you. This will be considered a denied claim. The notification will be sufficiently in advance of the reduction or termination to allow you to appeal the denial and receive a determination on appeal before the reduction or termination of the benefits. If you decide to appeal, you must follow the applicable appeals procedure described in If Your Claim Is Denied (for claims other than for outpatient prescription drugs and vision coverage) in this section.

**Notice and Payment of Claims**

The claims administrator will make a benefit determination on behalf of the plan and according to the plan’s provisions. You’ll receive a notice within the time limits described in the chart (see Plan notice of initial claim decision) under Initial Review and Decision in this section.

Please note that for an urgent care claim, you will receive notice (whether adverse or not) in writing or electronically. This notice also may be given orally, with a written or electronic confirmation to follow within three days.

If your claim is approved, benefits will be paid to you unless the provider notifies the claims administrator that your signature is on file, assigning benefits directly to that provider. The claims administrator will not reimburse third parties who have purchased or have been assigned benefits by doctors or other providers.

If your claim is denied, there is an additional procedure for appealing a denied decision.

You should also be aware that the claims administrators have the right to request repayment if they overpay a claim for any reason.
If Your Claim Is Denied
If your claim is denied (in whole or in part), you will receive a written notice that includes the following:

- Information sufficient to identify the claim involved.
- The reason(s) for the denial and the specific plan provision(s) upon which the denial was based.
- A description of any additional material or information that’s needed to complete the claim and an explanation of why such material or information is needed.
- An explanation of the plan’s appeals procedures and the time limits that apply to them (including a statement of your right to file suit following an adverse determination after completion of all levels of appeal/review required by the plan).
- Any additional information required by Department of Labor claim, appeal, and external review regulations.

Sometimes a claim is denied based on an internal rule, guideline, protocol or other similar item. If this happens, the notice will include a copy of the rule, guideline, protocol or item that was relied on to deny the claim. Alternatively, the notice will include a statement that an internal rule, guideline, protocol or similar item was relied on to deny your claim, and you can request a copy of it (the rule, guideline, protocol or other similar item) free of charge.

If your claim for benefits is denied based on medical necessity or experimental treatment or a similar exclusion or limit, the notice must include an explanation of the scientific or clinical judgment for the determination. It also must apply the terms of the plan to your medical circumstances. Alternatively, the notice will include a statement that such explanation will be provided to you free of charge upon request.

Before You Appeal
Before you officially appeal a denial of a claim, you can call the claims administrator to see if a resolution is possible. For example, the claims administrator may need more information to process your claim. However, if no further information is needed or if you aren’t satisfied with the explanation of why the claim was denied, you can request, in writing, to have the claim reviewed.

The claims administrator processes payments for claims, answers questions and reviews appeals according to the plan’s provisions.
How to File an Appeal
This section describes how to file an appeal with Cigna and the time limits that apply to the different types of prescription drug appeals.

<table>
<thead>
<tr>
<th>Time Limits</th>
<th>Types of Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urgent Care Health Claims</td>
</tr>
<tr>
<td>Your deadline to file a first appeal</td>
<td>180 days after receiving the claim denial notice.</td>
</tr>
<tr>
<td>Plan notice of first appeal decision</td>
<td>Not later than 24 hours after receiving an appeal.</td>
</tr>
<tr>
<td>Your deadline to file a second appeal</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>Plan notice of second appeal decision</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>Your deadline to request an External Review</td>
<td>Four months after receiving the appeal denial notice</td>
</tr>
<tr>
<td>IRO notice of External Review Decision</td>
<td>Not later than 72 hours after receiving the request</td>
</tr>
</tbody>
</table>

First Appeal
After receiving the notice of denial, you or your authorized representative (this can be your provider, your beneficiary, your legal representative or another appropriately authorized individual) may ask for an appeal, which is a full and fair review of the initial claim decision, by writing to the claims administrator. You must make this request for an appeal in writing within the time limits noted in the chart above.

During the time limit for requesting an appeal, upon request and free of charge, you or your authorized representative will be given reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits. You may also request to review the claim file.
Your appeal should include all of the following:

- Patient’s name and the identification number from the ID card.
- Date(s) of medical service(s).
- Provider’s name.
- Explanation of why you believe the claim should be paid.

You also can submit to the claims administrator any written comments, documents, records and other information or testimony relating to your claim for benefits.

For an urgent care claim, information may be provided by phone or fax.

Send your appeal to:

**Mail Delivery**

Cigna
P.O. Box 15050
Wilmington, DE 19850-5050

**Courier Delivery**

Cigna
300 Bellevue Parkway
Wilmington, DE 19809

**Time Limits and Procedures for Processing Your First Appeal**

Upon receipt of your appeal, the claims administrator will review the claim again and will make a decision based on all comments, documents, records and other information you’ve submitted, without regard to whether such information was submitted or considered in the initial benefit determination. This review will be completed within the time limits shown in the chart under Time Limits for Processing Appeals under How to File an Appeal in this section.

As part of the appeals procedure, these steps are followed:

- The review on appeal will not afford deference to the initial denial, and it will be conducted by a fiduciary who is neither the individual who initially denied the claim that is the subject of the appeal nor the subordinate of such individual.

- If your claim is denied based in whole or in part on a medical judgment — including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate — the fiduciary reviewing the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

- The health care professional consulted by the fiduciary reviewing the appeal will be an individual who is neither an individual who was consulted in connection with the denial of the claim that is the subject of the appeal nor the subordinate of such individual.
Upon your request, the claims administrator will identify any medical or vocational experts whose advice was obtained on behalf of the plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

If the claims administrator considers, relies upon, or generates any additional or new evidence during the appeal or if the claims administrator will base an impending denial upon any new or additional rationale, the claims administrator will provide such evidence or rationale as soon as possible in advance of the date the decision is due in order to give you a reasonable opportunity to respond prior to the decision being issued.

Notice of Decision on First Appeal
If, on the appeal, the claims administrator determines that your explanation and additional information support the payment of your claim, the claims administrator will process your claim. Benefits are paid to you unless the provider notifies the claims administrator that your signature is on file, assigning benefits directly to that provider.

If your first appeal is denied (in whole or in part), you will receive a written notice. The notice will contain information sufficient to identify the claim involved. The notice will state the reasons for the denial, including references to specific plan provisions upon which the denial was based and a statement of your right to file a civil lawsuit under Section 502 of ERISA following an adverse determination after completion of all levels of appeal/review required by the plan.

The notice will state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

If your appeal is denied based on an internal rule, guideline, protocol or other similar item, the notice will include a copy of the rule, guideline, protocol or item that was relied on to deny the claim. Alternatively, the notice will include a statement that an internal rule, guideline, protocol or similar item was relied on to deny your claim, and you can request a copy of it (the rule, guideline, protocol or other similar item) free of charge.

If your appeal is denied based on medical necessity or experimental treatment or a similar exclusion or limit, the notice must include an explanation of the scientific or clinical judgment for the determination. It also must apply the terms of the plan to your medical circumstances. Alternatively, the notice will include a statement that such explanation will be provided to you free of charge upon request.

The notice will include any additional information required by Department of Labor claim, appeal, and external review regulations.

If, on the appeal, the claims administrator upholds the denial of your claim, you may file a second appeal in accordance with Section 7.5 of the Certificate of Coverage. If, upon the second appeal, the claims administrator upholds the denial of your claim, you may file a request for an external review by contacting Cigna. In certain urgent cases, you may request an expedited external review. Contact Cigna for more information.
Customer Service

- Toll free: 1-800-828-5822
- Direct (collect calls accepted): 001-302-797-3871
- Toll-free facsimile number: 001-302-797-3150
- www.cignaenvoy.com

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P.O. Box 15050
Wilmington, DE 19850-5050

Courier Delivery
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300 Bellevue Parkway
Wilmington, DE 19809

Second Appeal
Under the Global Choice plan, you are allowed two levels of appeal (except for urgent care claims). After receiving the notice of denial of your first appeal, you or your authorized representative (this can be your provider, your beneficiary, your legal representative or another appropriately authorized individual) may ask for a second appeal. You must make this request for a second appeal in writing within the time limits noted in the chart above, Time Limits for Processing Appeals. The second appeal should also include any additional information that wasn’t previously submitted with your first appeal, as well as an explanation supporting your position.

Time Limits and Procedures for Processing Your Second Appeal
Upon receipt of your second appeal, the claims administrator reviews the claim again and makes a decision based on all comments, documents, records and other information you’ve submitted, without regard to whether such information was submitted or considered in the initial benefit determination.

This second appeal will be completed within the time limits shown in the chart above, Time Limits for Processing Appeals, in the Time Limits for Processing Medical Benefit Appeals section.

The second appeal will follow the same procedural steps as described for the first appeal. If the claims administrator considers, relies upon, or generates any additional or new evidence during the appeal or if the claims administrator will base an impending denial upon any new or additional rationale, the claims administrator will provide such evidence or rationale as soon as possible in advance of the date the decision is due in order to give you a reasonable opportunity to respond prior to the decision being issued.

Notice of Decision on Second Appeal
If, on second appeal, the claims administrator’s doctor or specialist determines that your explanation and additional information support the payment of your claim, the claims administrator will process your claim. Benefits are paid to you unless the provider notifies the claims administrator that your signature is on file, assigning benefits directly to that provider.

If your second appeal is denied (in whole or in part), you will receive a written notice. The notice will contain information sufficient to identify the claim involved. The notice will state the reasons for the denial, including references to specific plan provisions upon which the denial was based and a statement of your right to file a civil lawsuit under Section 502 of ERISA after all levels of required appeal/review have been exhausted. The notice will explain how to request an external review.
The notice will state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

If your second appeal is denied based on an internal rule, guideline, protocol or other similar item, the notice will include a copy of the rule, guideline, protocol or item that was relied on to deny the claim. Alternatively, the notice will include a statement that an internal rule, guideline, protocol or similar item was relied on to deny your claim, and you can request a copy of it (the rule, guideline, protocol or other similar item) free of charge.

If your second appeal is denied based on medical necessity or experimental treatment or a similar exclusion or limit, the notice must include an explanation of the scientific or clinical judgment for the determination. It also must apply the terms of the plan to your medical circumstances. Alternatively, the notice will include a statement that such explanation will be provided to you free of charge upon request.

The claims administrator is the named fiduciary that serves as the final review committee and, in its sole discretion, has the authority to interpret plan provisions, as well as facts and other information related to claims and appeals.

**Requesting an External Review**

If your second appeal is denied, you may have the right to request an external review. An external review will be provided only when the claim denial involved medical judgment (for example, a denial the plan’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit or a determination that a treatment is experimental or investigational) or the matter is a rescission of coverage.

A de minimis (small) deviation from strict adherence to the internal claims and appeals procedure on the part of the relevant claims administrator or review panel that does not cause, or is not likely to cause, prejudice or harm to the claimant will not waive the requirement to exhaust the internal claims and review procedure before obtaining an external review or filing a lawsuit. The claims administrator shall provide an explanation of such deviation within 10 days of the request of the claimant. If a request for external review is denied on account of the failure to exhaust the internal claims and appeals process when a de minimis deviation is involved, the claimant shall have the right to pursue the internal process.

You or your authorized representative can request an external review in writing or verbally to the claims administrator by following the instructions in your denial notice or writing to the claims administrator at the address listed in the Administrative Information section. The claims administrator will provide an external review procedure through an accredited Independent Review Organization (IRO) after determining the following:

- You were covered under the plan at the time the services were provided.
- The claim denial is not a result of failure to meet the requirements for eligibility under the plan.
- You have exhausted the appeal process described above.

The IRO will conduct an external review of an adverse benefit determination and issue a final external review decision. The claims administrator will provide case information to the IRO and notify you of the name and contact information for the IRO reviewing your request for external review. The IRO will communicate their external review decision to you and the claims administrator. If the IRO determines that your explanation and additional information support the payment of your claim, the claims administrator will immediately provide coverage or payment of the claim. If your external review is denied, you will receive a written notice from the IRO.
Expeditied External Review
You may request an expedited external review if any of the following apply:

- Your urgent care appeal is denied.
- The denial of your claim or appeal involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function.
- You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or if the final internal decision on review concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

To request an expedited external review, contact:

Customer Service
- Toll free: 1-800-828-5822
- Direct (collect calls accepted): 001-302-797-3871
- Toll-free facsimile number: 001-302-797-3150
- www.cignaenvoy.com

Mail Delivery
Cigna
P.O. Box 15050
Wilmington, DE 19850-5050

Courier Delivery
Cigna
300 Bellevue Parkway
Wilmington, DE 19809

Administrative Power and Responsibilities
Chevron Corporation has the discretionary authority to control and manage the administration and operation of the Omnibus Health Care Plan (the “Plan”). Chevron Corporation shall have the full, exclusive and discretionary authority to prescribe such forms; make such rules, regulations, interpretations and computations; construe the terms of the Plan; determine all issues relating to coverage and eligibility for benefits; and take such other action to administer the Plan as it may deem appropriate in its sole discretion. Chevron Corporation’s rules, regulations, interpretations, computations and actions shall be final and binding on all persons. Such discretionary authority can also be exercised by a delegate. The insurer has discretionary authority to act with respect to any appeal for a denial or benefits under the Global Choice Plan.
Prescription Drugs
Obtained INSIDE the U.S.
Chevron Prescription Drug Program – Express Scripts
## Overview of Prescription Drug Benefit (Express Scripts)

Covered prescription drugs purchased or obtained inside the U.S. are covered under the Chevron Prescription Drug Program, administered by Express Scripts. If you enroll in the Global Choice Plan, your benefit automatically includes this prescription drug coverage. This section describes the benefit for prescription drugs covered under the Prescription Drug Program.

The following table gives an overview of the benefits under the Prescription Drug Program. It highlights both the retail (network and out-of-network in the U.S.) and home delivery pharmacy service components of the program. To receive network prices, you must provide your Prescription Drug Program ID card or Express Scripts ID number at the time of purchase.

<table>
<thead>
<tr>
<th>Program Feature</th>
<th>Retail Pharmacy (U.S. network)</th>
<th>Retail Pharmacy (U.S. out-of-network)**</th>
<th>Home Delivery Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible (separate from medical deductible)</td>
<td>$150 individual $300 family</td>
<td>$150 individual $300 family</td>
<td>No deductible</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum (separate from medical plans’ annual out-of-pocket maximum)</td>
<td>$3,350 individual $6,700 family</td>
<td>$3,350 individual $6,700 family</td>
<td>$3,350 individual $6,700 family</td>
</tr>
<tr>
<td><strong>Generic Drugs</strong></td>
<td>After you pay the deductible, the plan pays:</td>
<td>After you pay the deductible, the plan pays:</td>
<td>The plan pays:</td>
</tr>
<tr>
<td></td>
<td>100% after you pay a $5 copayment for each 31-day supply</td>
<td>100% of network price after you pay a $5 copayment for each 31-day supply.</td>
<td>100% after you pay a $15 copayment for each 92-day supply</td>
</tr>
<tr>
<td><strong>Preferred Brand-Name Drugs</strong>*</td>
<td>80% You pay a $15 minimum for each 31-day supply</td>
<td>80% of network price You pay a $15 minimum for each 31-day supply.</td>
<td>85% You pay a $35 minimum for each 92-day supply.</td>
</tr>
<tr>
<td><strong>Nonpreferred Brand-Name Drugs</strong>*</td>
<td>70% You pay a $30 minimum for each 31-day supply</td>
<td>70% of network price You pay a $30 minimum for each 31-day supply.</td>
<td>75% You pay a $75 minimum for each 92-day supply.</td>
</tr>
<tr>
<td>Supply Limit</td>
<td>Up to a 365-day supply</td>
<td>Up to a 365-day supply</td>
<td>Up to a 365-day supply</td>
</tr>
</tbody>
</table>

*Generic Drugs vs. Brand-Name Drugs
If you or your doctor request a brand-name drug when a generic version of the drug is available (at a network or out-of-network pharmacy or through the mail), you pay the generic copayment plus the difference in cost between the brand-name drug and its generic equivalent unless your doctor provides the medical reason that the generic version of the drug will not work.

**Network Pharmacies vs. Out-of-Network Pharmacies
When you use a retail pharmacy in the U.S. that is out-of-network (or if you do not have your prescription ID card with you and the pharmacist is unable to verify your eligibility when you use a network pharmacy), you pay your coinsurance percentage or copayment (depending on the type of drug prescribed) plus the difference between the network discounted price and the out-of-network price for your prescription.
Prescription Drug Deductible (Express Scripts)

Your deductible is the amount of covered prescription drug charges for combined retail network and out-of-network benefits you pay each calendar year before the plan begins paying its share of those charges. The Prescription Drug Program deductible (which applies to prescription drugs obtained inside the U.S.) is separate from the deductible for the Global Choice Plan (which applies to medical services and prescription drugs obtained outside the U.S.).

<table>
<thead>
<tr>
<th>Coverage Tier</th>
<th>Annual Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>You Only</td>
<td>$150</td>
</tr>
<tr>
<td>You and Family (two or more)</td>
<td>$300</td>
</tr>
</tbody>
</table>

Each covered individual has a maximum deductible equal to the “You Only” deductible amount. For example, if you choose the “You and Family” coverage tier, your annual deductible is satisfied when the family's accumulation of deductibles reaches $300, with no more than $150 applied for each family member.

The following expenses don’t count toward the Prescription Drug Program deductible:

- Amounts you pay for prescriptions through the home delivery pharmacy program.

- The difference you pay between the cost of the generic and brand-name drug, if you choose a brand-name drug when a generic is available.

- The difference between the network pharmacy price and the out-of-network pharmacy price if you use an out-of-network pharmacy (or you don’t provide your ID at a network pharmacy).

- Charges for services or supplies that aren’t covered under the Prescription Drug Program, including drugs or services obtained outside the U.S. (may be covered by the medical portion of the Global Choice Plan).
Prescription Drug Out-of-Pocket Maximum Feature
(Express Scripts)

Under this feature, after your covered out-of-pocket costs reach the specified amount for the coverage tier, the Prescription Drug Program pays 100 percent of all covered charges until the end of the calendar year. The Prescription Drug Program out-of-pocket maximum (which applies to prescription drugs obtained inside the U.S.) is separate from the out-of-pocket maximum for the Global Choice Plan (which applies to prescription drugs obtained outside the U.S. and medical services).

<table>
<thead>
<tr>
<th>Coverage Tier</th>
<th>Annual Out-of-Pocket Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>You Only</td>
<td>$3,350</td>
</tr>
<tr>
<td>You and Family (two or more)</td>
<td>$6,700</td>
</tr>
</tbody>
</table>

Each covered individual has an out-of-pocket maximum equal to the You Only amount. For example, if you choose the You and Family coverage tier, your annual out-of-pocket maximum is satisfied when the family’s accumulation of out-of-pocket maximums reaches $6,700, with no more than $3,350 applied for each family member.

The following expenses don’t count toward the Prescription Drug Program out-of-pocket maximum, nor are they part of the 100 percent reimbursement after you reach your out-of-pocket maximums:

- Your deductible expenses.
- The difference you pay between the cost of the generic and brand-name drug, if you choose a brand-name drug when a generic is available.
- The difference between the network pharmacy price and the out-of-network pharmacy price, if you use an out-of-network pharmacy (or you don’t provide your ID at a network pharmacy).
- Charges for services or supplies that aren’t covered under the Prescription Drug Program, including drugs or services obtained outside the U.S. (which may be covered by the medical portion of the Global Choice Plan).
Covered Medication (Express Scripts)

For a prescription drug or device to be covered under the plan's Prescription Drug Program, the medication must qualify as follows:

- It must be prescribed on an outpatient basis by a doctor.
- It must be approved by the Federal Food and Drug Administration (FDA).
- It must be dispensed by a licensed pharmacist.
- It cannot be sold over the counter except as required by the Patient Protection Affordable Care Act.
- It cannot be specifically excluded by the Prescription Drug Program.

In addition, the program covers:

- Insulin, insulin needles and syringes.
- Diabetic supplies (such as lancets and urine and blood test strips and tapes).

If an existing drug changes or when new drugs are approved by the FDA, they also must meet the above criteria before the drug is covered under the Prescription Drug Program. Further, Chevron has the right to determine which drugs will be covered, limited or excluded under the plans’ Prescription Drug Program.

Most kinds of prescription medication are covered under the Prescription Drug Program if the above criteria are met, including the following drugs and supplies:

- Smoking deterrents (covered at 100%, with no deductible).
- Prescribed FDA approved female contraceptive methods including prescribed contraceptives which can be purchased over-the-counter (covered at 100%, with no deductible).
- Prescription vitamins (not over-the-counter), including prenatal vitamins.
- Retin-A, covered up to age 34.
- Needles, syringes and injectable medications.
- Fluoride supplementations for dependents six months old through age 5 (covered at 100%, with no deductible).
• Doctor prescribed medications for preventive care as required by the Patient Protection and Affordable Care Act with no deductible for certain generic over-the-counter drugs and generic prescription drugs. Examples of the medications are:

  - Aspirin to prevent cardiovascular events (men age 45 – 79, women age 55 – 79)
  - Folic Acid (women through age 50)
  - Iron Supplements (children age 6 – 12 months who are at increased for iron deficiency anemia)
  - Vitamin D (men and women over the age of 65 who are at increased risk for falls)
  - Bowel Preps (men and women age 50 – 75); coverage is for generic and single-source prescription drugs and generic over-the-counter products. Limited to a maximum of two prescriptions per 365 days.

For more information about which drugs aren't covered under the Prescription Drug Program, see Drugs That Aren't Covered in this section.
Prior Authorization
The Prescription Drug Program covers some drugs only if they’re prescribed for certain uses or only up to certain quantity levels. For this reason, some medications must be approved in advance before you can receive plan benefits. Drugs requiring prior authorization include:

- Growth hormones.
- Androgens.
- Drugs for multiple sclerosis such as Copaxone.
- Beta-interferon drugs, such as Avonex and Betaseron.
- Erythroid/myeloid stimulants.
- Neumega.
- Retin-A, Avita, and Altinac creams after age 34.
- Xyrem for the treatment of narcolepsy.
- Xenazine, Cinryze, Arclyst, and Solaris.
- Anti-fungal agents, such as Noxafil
- Specialty pulmonary agents for treatment of cystic fibrosis, including Pulmozyme.
- Specialty drugs for the treatment of psoriasis, including Stelara.
- Specialty drugs for the treatment of pulmonary arterial hypertension, including Adcirca, Letairis, Remodulin, Revatio, Tracleer, Tyvaso, Ventavis.
- Miscellaneous specialty pulmonary agents, including Tobi and Crayston.
- Acthar Gel.
- Specialty drugs for the treatment of Hepatitis C, including Incivek and Victrelis.

A drug that is a type of drug listed above but is not specifically named above may be subject to the prior authorization requirements.

For any drugs that require prior authorization, your network pharmacist or Express Scripts home delivery pharmacist can begin the approval process by contacting your doctor to review the therapy and determine whether the drug can be covered. You and your doctor will be notified when this process is completed. If the medication isn’t approved, you’ll be responsible for paying the full cost of the drug.

Note: Certain controlled substances and several other prescribed medications, including hypnotics (sleeping pills); migraine medications, and antifungals, may be subject to dispensing limitations and the
professional judgment of the pharmacist. If you have any questions about your medication, please call Express Scripts Member Services at 1-800-987-8368.

**Medical Channel Management**

Certain specialty drugs that are self-administered are covered only if they are ordered through the Express Scripts Specialty Pharmacy, Accredo. They will not be covered if supplied by your doctor or another pharmacy. Examples of conditions that are subject to Medical Channel Management are:

- Cancer – oral medications
- Growth Stimulating Agents
- Hemophilia – nasal medications
- HIV
- Immune Deficiency
- Infertility
- Metabolic Disorders
- Multiple Sclerosis
- Osteoporosis
- Parkinson’s Disease
- Pulmonary – Cystic Fibrosis
- Rheumatoid Arthritis and other Autoimmune Conditions
- Short Bowel Disease

The list of specialty drugs subject to Medical Channel Management may change so you should check the list before you fill a prescription for a specialty medication. Call 1-800-987-8368 for a complete list of medications subject to this program.
Drugs That Aren’t Covered (Express Scripts)

The following drugs, supplies and services aren’t covered under the Prescription Drug Program:

- Nonfederal legend drugs, including over-the-counter medications, unless otherwise specified in the Prescription Drug Program as covered.
- Anorexiants and appetite suppressants.
- Topical fluoride products except as required by the Patient Protection and Affordable Care Act.
- Retin-A, Avita and Altinac creams after age 34, unless prior authorization is obtained from Express Scripts.
- Blood glucose testing monitors (covered under the medical portion of the Global Choice Plan).
- Therapeutic devices or appliances (including durable medical equipment).
- Drugs designed solely to promote or stimulate hair growth (including Rogaine and Propecia) or for cosmetic purposes only (such as Renova).
- Allergy serums (may be covered under another part of the Global Choice Plan).
- Immunization agents and vaccines.
- Biologicals and blood or blood plasma products.
- Drugs designated under federal law for investigational use or as experimental drugs, even if you’re charged for the drugs.
- Refills in excess of the number prescribed by your doctor or dispensed more than one year after your doctor gave you the prescription.
- Drugs that are prescribed as part of your treatment while you are an inpatient in any facility, such as a hospital or skilled nursing facility that has a facility for dispensing drugs on its premises.
- Charges for the administration or injection of any drug.
- Drugs or services obtained outside the U.S. (which may be covered by the medical portion of the Global Choice Plan).
- Nonsedating antihistamines.

In addition, charges are covered only if you file your claim within one year after your prescription is filled. Please note that this may be different from the time period to file medical or non-U.S. prescription drug claims.
When You Go to a Network Pharmacy (In the U.S.)
(Express Scripts)

You can fill prescriptions for up to a 365-day supply of covered medication at any Express Scripts network pharmacy. Here’s how:

1. Show your prescription ID card to the pharmacist or provide your Express Scripts ID number when you hand in your prescription. Your eligibility will be confirmed by a computerized system. Generally, after you meet your deductible, you will pay the following:
   - $5 for each 31-day supply of generic drugs.
   - 20 percent of the discounted cost for preferred brand-name drugs.
   - 30 percent of the discounted cost for nonpreferred brand-name drugs.

In addition, there is a $15 minimum payment each 31-day supply preferred brand-name drug, and a $30 minimum each 31-day supply of non-preferred drugs, up to the total cost of the drug.

You’ll receive a generic version of the drug, unless a generic version is not available. If your doctor specifies that you receive a brand-name drug instead of a generic drug (by writing "Dispense as Written" on your prescription), or if you tell the pharmacist that you want a brand-name drug, even when a generic is available, your prescription will be filled with a brand-name drug. You’ll pay a $5 generic copayment plus the difference between the cost of the brand-name drug and the generic drug unless your doctor provides the medical reason that neither the generic version of the drug, or other covered drugs that treat the same condition will work. In that case, you will not pay the difference between the cost of the brand-name drug and the generic drug.

The paragraph above doesn’t apply to covered charges for smoking deterrents and fluoride supplements.

2. The pharmacist will process your prescription, using the program’s computer system to confirm your eligibility, and make sure the drug is covered under the plan. The computer system may notify the pharmacist if there’s a potential problem with the prescription (such as a risk of adverse interaction with other drugs you’re taking).

Note: If you need a year’s supply, make sure your doctor writes the prescription for one year or 365 days (not 30-days with refills), and includes the dose per day. Prescriptions must be written by a U.S.-licensed doctor. Certain controlled substances, by law, may be limited to less than a 365 day supply.
When You Go to an Out-of-Network Pharmacy (In the U.S.)
(Express Scripts)

If you go to a pharmacy that's out-of-network to fill prescriptions or you don't provide your ID, you pay the pharmacist the full price of the prescription and file a claim form.

Once you file the claim, and after you meet your annual deductible, you are reimbursed according to the following coinsurance levels:

- 100 percent of the discounted cost for generic drugs after a $5 copayment for each 31-day supply.
- 80 percent of the discounted cost for preferred brand-name drugs.
- 70 percent of the discounted cost for brand-name nonpreferred drugs.

You will not be reimbursed for the difference between the discounted network pharmacy price and the out-of-network pharmacy price for your prescription.

In addition, there is a $15 minimum payment for each 31-day supply of preferred brand-name drugs and $30 minimum payment for each 31-day supply of non-preferred drugs, up to the total cost of the drug.

In addition, if your doctor specifies that you receive a brand-name drug instead of a generic drug (by writing “Dispense as Written” on your prescription), or if you tell the pharmacist that you want a brand-name drug, even when a generic is available, your prescription will be filled with a brand-name drug. If you choose the brand-name drug when a generic is available, you also pay the difference between the generic and the brand-name drug unless your doctor provides the medical reason that neither the generic version of the drug, or other covered drugs that treat the same condition will work. In that case, you will not pay the difference between the cost of the brand-name drug and the generic drug.

The paragraph above doesn’t apply to covered charges for smoking deterrents and fluoride supplements.
Home Delivery Pharmacy Program (Express Scripts)

The Prescription Drug Program’s home delivery pharmacy services are administered by Express-Scripts. You can order up to a 365-day supply of covered prescription drugs without a deductible. You should use this part of the program when you need maintenance medication, when possible. Please note: a prescription obtained through the home delivery pharmacy program cannot be mailed to an address outside the U.S. See the Prescription Drugs Obtained Outside the U.S. section for further instructions and information about prescriptions under the Global Choice Plan.

When you use the home delivery pharmacy to fill a prescription, you will generally pay the following amounts for each 92-day (or less) supply:

- $15 for generic drugs (up to the total cost of the drug).
- 15 percent for preferred brand-name drugs, with a $35 minimum (up to the total cost of the drug).
- 25 percent for nonpreferred brand-name drugs, with a $75 minimum (up to the total cost of the drug).

To encourage the use of more cost-effective generics, if you choose a brand-name drug when a generic version of the drug is available, or if your doctor specifies that you receive a brand-name drug by writing “Dispense as Written” on your prescription, you will pay the $15 generic copayment plus the difference between the brand-name and the generic version unless your doctor provides the medical reason that neither the generic version of the drug, or other covered drugs that treat the same condition will work. In that case, you will not pay the difference between the cost of the brand-name drug and the generic drug.

The paragraph above doesn’t apply to covered charges for smoking deterrents and fluoride supplements.

Important Note: Because of the time required for mail-order shipments, this mail-order part of the Prescription Drug Program isn’t suitable if there’s not sufficient time before you depart for your foreign assignment. Allow a minimum of two to three weeks for new prescriptions.
How to Order Medication by Mail

- Ask your doctor for a prescription for up to a 365-day supply of medication. If you need a year’s supply, make sure the prescription is written for one year or 365 days (not 90 days with refills), and includes the dose per day. Certain controlled substances, by law, may be limited to less than a 365 day supply.

- Your doctor can fax your prescriptions to Express Scripts. Ask your doctor to call 1-888-327-9791 for faxing instructions. Then call Express Scripts Member Services to make sure they have a valid telephone number and shipping address for you.

- If time permits, you can also mail your prescription to Express Scripts. Please allow a minimum of two to three weeks for delivery. Call Express Scripts Member Services for the home delivery pharmacy address closest to where you want your medications mailed.

- Complete an order form and health assessment questionnaire (for your first order only), included in your information packet or available from Express Scripts Member Services at 1-800-987-8368. You can also request home delivery forms and envelopes by visiting www.express-scripts.com.

- Check your doctor’s prescription form to make sure it includes the correct dosage, your doctor’s signature, and your name and address (or your covered dependent’s name and address).

- Write your Prescription Drug Program ID number (found on your prescription ID card) on the back of the prescription slip.

- Use the envelope provided with your order form to send in the original prescription slip, your completed order form and your share of the cost of the drugs. Send your completed health assessment questionnaire in the separate envelope provided. Please allow up to 21 days for delivery. You can request express delivery at additional cost.

- If you have recently filled a 90-day supply of the same medication and have more than one month remaining, you need to call Express Scripts and ask them to send a message to the Client Service Team requesting an override to the Refill Too Soon restriction. You need to do this before you or your doctor sends in the prescription. The override request can take up to 48 hours to take effect.

- **Note:** Express Scripts can only fill prescriptions written by U.S.-licensed doctors and can only mail to addresses within the United States. Also, the shelf life for some medications may be less than 365 days, in which case the home delivery pharmacy will not be able to supply the full amount. You can pay your share of home delivery pharmacy costs with a personal check or money order, or you can charge it on your MasterCard, Visa, American Express, Diners or Discover credit card by writing your charge account number and expiration date on the order form. If you do not use a credit card or provide another form of payment when you submit your order, Express Scripts will fill your prescription and send it to you as long as the order is no more than $100. (Express Scripts will bill you later.) If your order is over $100, Express Scripts will not fill your prescription without payment. For an estimate of the cost of your prescription, visit www.Express-Scripts.com or call Express Scripts Member Services at 1-800-987-8368.
How to File a Prescription Drug Claim with Express Scripts

This section describes how to file a claim for outpatient prescription drug benefits obtained inside the U.S. that you believe are covered by the Chevron Prescription Drug Program. For prescriptions filled outside the U.S., see Prescription Drugs Obtained Outside the U.S. section of this summary plan description. If your dispute concerns eligibility to participate in the plan, you must follow the procedures described in the How to File a Claim for Eligibility section of this summary plan description.

Express Scripts is the claims administrator for the Prescription Drug Program. Express Scripts processes payments for claims, answers questions and reviews appeals according to the plan’s provisions. Express Scripts, as claims administrator, is the named fiduciary that, in its sole discretion, has the authority to interpret plan provisions, as well as facts and other information related to claims and appeals of outpatient prescription drug claims.

If your prescriptions are filled at a network pharmacy or through the program’s home delivery pharmacy, you pay your share of the cost when you order the medication you need. There are no claim forms to fill out. You’ll generally need to file a claim when:

- Your prescription is filled at an out-of-network pharmacy in the U.S.
- Your prescription is filled at a network pharmacy, but you don’t have your prescription ID and the pharmacist is unable to verify your coverage.
- You submit a request for a prescription drug at a network pharmacy and your request is denied (for example, your ID card is rejected).

In these situations you must pay the full price for your medication and send in a completed claim form to request reimbursement of covered charges.

In addition, charges are covered only if you file your claim within one year after your prescription is filled. Please note that this may be different from the time period to file medical or non-U.S. prescription drug claims.

You can call Express Scripts Member Services at 1-800-987-8368 to request a claim form or you can obtain forms from Express Script’s website at www.express-scripts.com. Claim forms are also available on the Benefits Connection website at http://www.benefitsweb.com/chevron.html or from the HR Service Center at 1-888-825-5247, option 2, (610-669-8595 outside the U.S.).
When you fill out the claim form, use your full name and your member ID number located on your Express Scripts ID card. Attach the original receipt from the pharmacy. The receipt must contain the following information:

- Date prescription was filled.
- Name and address of the pharmacy.
- National Drug Code (NDC) number.
- Name of drug and strength.
- Quantity.
- Prescription (Rx) number.
- “Dispense as Written,” if applicable.
- Amount paid for the medication.

Mail the completed claim form to the address shown on the form.

If your claim is denied (in whole or in part), or if Express Scripts needs more information before it can approve your claim, you’ll be notified in writing. When a claim is denied, you can appeal the denial as described below.

**Note:** For information on how to file a medical benefit claim or a basic vision claim, please see the medical coverage and basic vision coverage sections.

You also should be aware that Express Scripts has the right to request repayment if it overpays a claim for any reason.
Prescription Drug Claim Reviews and Appeals with Express Scripts

Initial Review and Decision

Claims for Prior Authorization and Dispense as Written (DAW) Prescription Drug Benefits
Express Scripts reviews all claims for prescription drugs that require prior authorization and for prescriptions for which your doctor requests “Dispensed as Written” (DAW). When a prescription falls within these categories and you present it at a retail network pharmacy or submit it to the home delivery pharmacy, this information is electronically transmitted to Express Scripts. On behalf of the Prescription Drug Program and according to the Prescription Drug Program’s provisions, Express Scripts will make a benefit determination within the following time limits:

- **Retail Network Pharmacy** - Within 15 days of receipt of the request for coverage, Express Scripts will make a determination on a prescription presented at a retail network pharmacy. If additional information is required to make the determination, a fax will be sent to the prescribing doctor requesting the necessary information. If the required information is not received within 45 days, the claim will be denied based on lack of information.

- **Home Delivery Pharmacy** - Within 15 days of receipt of the request for coverage, Express Scripts will make a determination on a prescription submitted to a home delivery pharmacy. If additional information is required to make the determination, the prescribing doctor will be contacted by fax or phone with a request for the necessary information. If the required information is not received within 45 days, the claim will be denied based on lack of information.

Urgent Care Claims
An urgent care claim is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or which, in the opinion of your doctor, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If your coverage request is an urgent care claim, Express Scripts will make a determination on a prescription presented at a retail network pharmacy or submitted to a home delivery pharmacy not later than 72 hours after receiving the initial claim, if it was properly made and no additional information is required. If additional information is required to make the determination, the prescribing doctor will be contacted by fax or phone with a request for the necessary information. Your doctor will have 48 hours to provide the additional information requested. In this case, Express Scripts will make a determination not later than 48 hours after receiving the additional information or after the expiration of the 48-hour deadline to provide such information, whichever is earlier.
Claims for Other Prescription Drug Benefits
If you present a prescription for a drug that does not require prior authorization or for a drug for which your
doctor has not requested "Dispensed as Written," either at a retail pharmacy or through the home delivery
pharmacy, and your request is denied, you can contact Express Scripts for an explanation. If you are not
satisfied with the explanation provided by Express Scripts, you can file a claim for benefits by writing to
Express Scripts at the following address:

Express Scripts
P.O. Box 631850
Irving, TX 75063-0030

Your claim will be processed within the time limits set forth in the chart below, Time Limits for Processing
Prescription Drug Appeals under How to File an Appeal in this section.

If your claim is approved, benefits will be paid to the pharmacy unless you have already paid for the
prescription drug, in which case benefits will be payable to you. When a written claim is denied, you can
appeal the denial.

If Your Prescription Drug Claim Is Denied
If your prescription drug claim is denied (in whole or in part), you will receive a written notice from
Express Scripts that includes all of the following:

- Information sufficient to identify the claim involved.
- The reason(s) for the denial and the plan provision(s) upon which the denial was based.
- A description of any additional material or information that's needed to complete the claim and an
  explanation of why such material or information is needed.
- An explanation of the plan’s appeals procedures and the time limits that apply to them (including a
  statement of your right to file a civil lawsuit under Section 502(a) of ERISA following an adverse
determination after completion of all levels of appeal/review required by the plan).
- Any additional information required by Department of Labor claim, appeal, and external review
  regulations.

Sometimes a claim is denied based on an internal rule, guideline, protocol or other similar item. If this
happens, the notice will include a copy of the rule, guideline, protocol or item that was relied on to deny the
claim. Alternatively, the notice will include a statement that an internal rule, guideline, protocol or similar
item was relied on to deny your claim, and you can request a copy of it (the rule, guideline, protocol or
other similar item) free of charge.

If your claim for benefits is denied based on medical necessity or experimental treatment or a similar
exclusion or limit, the notice must include an explanation of the scientific or clinical judgment for the
determination. It also must apply the terms of the plan to your medical circumstances. Alternatively, the
notice will include a statement that such explanation will be provided to you free of charge upon request.
How to File an Appeal
This section describes how to file an appeal with Express Scripts and the time limits that apply to the different types of prescription drug appeals.

<table>
<thead>
<tr>
<th>Time Limits</th>
<th>Urgent Care Prescription Drug Claims</th>
<th>All Other Prescription Drug Claims (except member-submitted paper claims)</th>
<th>Member-Submitted Paper Claims for Prescription Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your deadline to file a first appeal</td>
<td>180 days after receiving the claim denial notice.</td>
<td>180 days after receiving the claim denial notice.</td>
<td>180 days after receiving the claim denial notice.</td>
</tr>
<tr>
<td>Plan notice of first appeal decision</td>
<td>Not later than 72 hours after receiving an appeal.</td>
<td>Not later than 15 days after receiving an appeal.</td>
<td>Not later than 30 days after receiving an appeal.</td>
</tr>
<tr>
<td>Your deadline to file a second appeal</td>
<td>N/A</td>
<td>90 days after receiving the first appeal denial notice.</td>
<td>90 days after receiving the first appeal denial notice.</td>
</tr>
<tr>
<td>Plan notice of second appeal decision</td>
<td>N/A</td>
<td>Not later than 15 days after receiving a second appeal.</td>
<td>Not later than 30 days after receiving a second appeal.</td>
</tr>
<tr>
<td>Your deadline to request an External Review</td>
<td>Four months after receiving the appeal denial notice</td>
<td>Four months after receiving the second appeal denial notice</td>
<td>Four months after receiving the second appeal denial notice</td>
</tr>
<tr>
<td>IRO notice of External Review Decision</td>
<td>Not later than 72 hours after receiving the request for external review</td>
<td>Not later than 45 days after receiving the request for external review</td>
<td>Not later than 45 days after receiving the request for external review</td>
</tr>
</tbody>
</table>

First Appeal
After receiving the notice of denial, you or your authorized representative (this can be your provider, your beneficiary, your legal representative or another appropriately authorized individual) may ask for an appeal, which is a full and fair review of the initial claim decision, by writing to Express Scripts. Your first appeal must be submitted in writing within 180 days after the claim is denied.

During the time limit for requesting a first appeal, you or your authorized representative will be given reasonable access to all documents and information (other than legally or medically privileged documents) relevant to the claim, and you may request copies free of charge. You may also request to review the claim file. You also can submit written comments, documents, records and other information pertinent to your claim to Express Scripts.
Your written first appeal should include the following information:

- Your full name even if the claim is for your dependent.
- Your member id number located on your Express Scripts ID Card.
- Your phone number.
- The prescription drug for which coverage has been denied.
- An explanation of why you believe the prescription drug should be covered.
- Any supporting information or documentation.

For a prescription drug claim only, send your written request for a first appeal to:

Express Scripts
P.O. Box 631850
Irving, TX 75063-0030

If your urgent care claim is denied, you have the right to request an urgent appeal of the adverse determination. Urgent appeal requests may be oral or written. You or your doctor can call 1-800-987-8368 or send a written appeal request to the above address. In the case of an appeal for coverage involving an urgent care claim, you will be notified of the benefit determination within 72 hours of receipt of the appeal. This coverage decision is final and binding. There is only one level of internal appeal for an urgent care claim, but you may request an expedited external review of a denial of an appeal involving urgent care.

**Time Limits and Procedures for Processing Your First Appeal**

Upon receipt of your first appeal, Express Scripts will review the claim again and make a decision based on all comments, documents, records and other information you’ve submitted, without regard to whether such information was submitted or considered in the initial benefit determination. Express Scripts will make its determination on your first appeal in accordance with the time limits shown in the chart, Time Limits for Processing Prescription Drug Appeals, in this section. The review on appeal will not afford deference to the initial denial, and it will be conducted by a fiduciary who is neither the individual who initially denied the claim that is the subject of the appeal nor the subordinate of such individual.

If the claims administrator considers, relies upon, or generates any additional or new evidence during the appeal or if the claims administrator will base an impending denial upon any new or additional rationale, the claims administrator will provide such evidence or rationale as soon as possible in advance of the date the decision is due in order to give you a reasonable opportunity to respond prior to the decision being issued.
Notice of Decision on First Appeal
If, on first appeal, Express Scripts determines that your explanation and additional information support the payment of your claim, Express Scripts will process your prescription and benefits will be paid to the pharmacy, unless you have already paid for the prescription drug, in which case benefits will be payable to you.

If your first appeal is denied (in whole or in part), you will receive a written notice. The notice will contain information sufficient to identify the claim involved. The notice will state the reasons for the denial, including references to specific plan provisions upon which the denial was based and a statement of your right to file a civil lawsuit under Section 502(a) of ERISA following an adverse determination after completion of all levels of appeal/review required by the plan. The notice will state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

If, on first appeal, Express Scripts upholds the denial of your claim, you may file a second appeal within 90 days after receiving the notice of denial of your first appeal. However, there is only one level of internal appeal for an urgent care claim.

Sometimes a claim or appeal is denied based on an internal rule, guideline, protocol or other similar item. If this happens, the notice will include a copy of the rule, guideline, protocol or item that was relied on to deny the claim. Alternatively, the notice will include a statement that an internal rule, guideline, protocol or similar item was relied on to deny your claim, and you can request a copy of it (the rule, guideline, protocol or other similar item) free of charge.

If your appeal is denied based on medical necessity or experimental treatment or a similar exclusion or limit, the notice must include an explanation of the scientific or clinical judgment for the determination. It also must apply the terms of the plan to your medical circumstances. Alternatively, the notice will include a statement that such explanation will be provided to you free of charge upon request.

The notice will include any additional information required by Department of Labor claim, appeal, and external review regulations.

Express Scripts is the named fiduciary that serves as the review committee and, in its sole discretion, has the authority to interpret plan provisions, as well as facts and other information related to claims for which a first appeal is requested.

Second Appeal
After receiving the notice of denial of your first appeal, you or your authorized representative (this can be your provider, your beneficiary, your legal representative or another appropriately authorized individual) may ask for a second appeal.

During the time limit for requesting a second appeal, you or your authorized representative will be given reasonable access to all documents and information (other than legally or medically privileged documents) relevant to the claim, and you may request copies free of charge. You may also request to review the claim file. You also can submit written comments, documents, records and other information or testimony pertinent to your claim to Express Scripts.
Your second appeal must be submitted in writing within 90 days after your first appeal is denied. Your written second appeal should include the following information:

- Your full name even if the claim is for your dependent.
- Your member id number located on your Express Scripts ID card.
- Your phone number.
- The prescription drug for which coverage has been denied.
- An explanation of why you believe the prescription drug should be covered.
- Any supporting information or documentation.

The second appeal should also include any additional information that wasn’t previously submitted with your first appeal, as well as an explanation supporting your position.

For a prescription drug claim only, send your written request for a second appeal to:

Express Scripts.
P.O. Box 631850
Irving, TX 75063-0030

**Time Limits and Procedures for Processing Your Second Appeal**

Upon receipt of your second appeal, Express Scripts will review the claim again and make a decision based on all comments, documents, records and other information you’ve submitted, without regard to whether such information was submitted or considered in the initial benefit determination. Express Scripts will make its determination on your second appeal in accordance with the time limits shown in the chart, Time Limits for Processing Prescription Drug Appeals, in this section.

The review on second appeal will not afford deference to the initial denial, and it will be conducted by a fiduciary who is neither the individual who denied the claim or first appeal nor the subordinate of such individuals.

The second appeal will follow the same procedural steps as described for the first appeal.

If the claims administrator considers, relies upon, or generates any additional or new evidence during the second appeal or if the claims administrator will base an impending denial upon any new or additional rationale, the claims administrator will provide such evidence or rationale as soon as possible in advance of the date the decision is due in order to give you a reasonable opportunity to respond prior to the decision being issued.
Notice of Decision on Second Appeal

If, on second appeal, Express Scripts determines that your explanation and additional information support the payment of your claim, Express Scripts will process your prescription and benefits will be paid to the pharmacy, unless you have already paid for the prescription drug, in which case benefits will be payable to you.

If your second appeal is denied (in whole or in part), you will receive a written notice. The notice will contain information sufficient to identify the claim involved. The notice will state the reasons for the denial, including references to specific plan provisions upon which the denial was based and a statement of your right to file a civil lawsuit under Section 502(a) of ERISA after all levels of required appeal/review have been exhausted. The notice will explain how to request an external review.

The notice will state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

Sometimes a claim is denied based on an internal rule, guideline, protocol or other similar item. If this happens, the notice will include a copy of the rule, guideline, protocol or item that was relied on to deny the claim. Alternatively, the notice will include a statement that an internal rule, guideline, protocol or similar item was relied on to deny your claim, and you can request a copy of it (the rule, guideline, protocol or other similar item) free of charge.

If your appeal is denied based on medical necessity or experimental treatment or a similar exclusion or limit, the notice must include an explanation of the scientific or clinical judgment for the determination. It also must apply the terms of the plan to your medical circumstances. Alternatively, the notice will include a statement that such explanation will be provided to you free of charge upon request.

The notice will include any additional information required by Department of Labor claim, appeal, and external review regulations.

Express Scripts is the named fiduciary that serves as the review committee and, in its sole discretion, has the authority to interpret plan provisions, as well as facts and other information related to claims for which a second appeal is requested.

Requesting an External Review

If your second appeal is denied, you may have the right to request an external review. An external review will be provided only when the claim denial involved medical judgment (for example, a denial the plan’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit or a determination that a treatment is experimental or investigational) or the matter is a rescission of coverage.

A de minimis (small) deviation from strict adherence to the internal claims and appeals procedure on the part of the relevant claims administrator or review panel that does not cause, or is not likely to cause, prejudice or harm to the claimant will not waive the requirement to exhaust the internal claims and review procedure before obtaining an external review or filing a lawsuit. The claims administrator shall provide an explanation of such deviation within 10 days of the request of the claimant. If a request for external review is denied on account of the failure to exhaust the internal claims and appeals process when a de minimis deviation is involved, the claimant shall have the right to pursue the internal process.

You or your authorized representative can request an external review in writing or verbally to Express Scripts by following instructions in your denial letter or contacting Express Scripts at:
You must request the external review within four months after the date of receipt of a denial of your second appeal. Express Scripts will provide an external review procedure through an accredited Independent Review Organization (IRO) after determining the following:

- You were covered under the plan at the time the services were provided.
- The claim denial is not a result of failure to meet the requirements for eligibility under the plan.
- You have exhausted the appeal process described above.

Within one business day of completing the preliminary review, Express Scripts will notify you in writing of the name and contact information for the IRO reviewing your request for external review. The notice will include a statement that you may submit in writing to the IRO within 10 business days any additional information that you want the IRO to consider when conducting the external review.

Within five business days after the date of assignment to the IRO, Express Scripts will provide to the IRO the documents and any information considered in making the adverse benefit determination, and the terms of the Prescription Drug Program.

The IRO will conduct an external review of an adverse benefit determination and issue a final external review decision. The IRO will communicate their external review decision to you and to Express Scripts. If the IRO determines that your explanation and additional information support the payment of your claim, Express Scripts will immediately provide coverage or payment of the claim. If your external review is denied, you will receive a written notice from the IRO within 45 days.
**Expedited External Review**

You may request an expedited external review if any of the following apply:

- Your urgent care appeal is denied.

- The denial of your claim or appeal involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function.

- You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or if the final internal decision on review concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

To request an expedited external review, contact Express Scripts:

Express Scripts  
Attn: External Review Requests  
P.O. Box 631850  
Irving, TX 75063-0030

1-800-753-28512  
1-888-235-8551 (fax)

**Administrative Power and Responsibilities**

Chevron Corporation has the discretionary authority to control and manage the administration and operation of the Omnibus Health Care Plan (the “Plan”). Chevron Corporation shall have the full, exclusive and discretionary authority to prescribe such forms; make such rules, regulations, interpretations and computations; construe the terms of the Plan; determine all issues relating to coverage and eligibility for benefits; and take such other action to administer the Plan as it may deem appropriate in its sole discretion. Chevron Corporation’s rules, regulations, interpretations, computations and actions shall be final and binding on all persons. Such discretionary authority can also be exercised by a delegate.
If You’re Covered by More Than One Health Plan
Prescription Drug Program

If you or one of your dependents is covered by more than one group medical plan when you use the home delivery pharmacy or when you present your Prescription Drug Program ID card at a network retail pharmacy, Express Scripts will cover the drug as if it is the primary payer, regardless of which plan is primary, and you don’t have to submit a claim form. However, if you or one of your dependents is covered by more than one health care plan and does not utilize the home delivery pharmacy or present a Prescription Drug Program ID Card at a retail pharmacy then this Prescription Drug Program is the secondary plan, or if you want the Prescription Drug Program to be the secondary payer, you must submit a claim form, along with the documentation requested on the form to Express Scripts. Be sure to indicate that you are requesting reimbursement under the coordination of benefits feature.

In this case, provided you or your dependent, as applicable, has met the deductible requirement under this Prescription Drug Program, if allowable medical expenses exceed the amount covered by all primary plans, the benefit under this Prescription Drug Program will be the lesser of the amount submitted or what the primary plan(s) did not pay for the prescription drug, up to the maximum amount this Prescription Drug Program would have paid if this Prescription Drug Program were the primary plan. Any Prescription Drug Program co-insurance requirements also apply. Under no circumstances will the sum of the benefits paid from each plan exceed the actual expense incurred.

**Note:** Coordination of benefits does not apply to benefits payable under any private accident or health insurance plans. Also, it does not apply to benefits payable under any other group insurance or health care plan maintained by Chevron. However, the plans do coordinate benefits with the Dental Plan in case of accidental injury to teeth.
Basic Vision Coverage

This section provides a description of the vision coverage that's part of the Global Choice Plan (U.S.-Payroll Expatriates) for you and your eligible dependents.

- Chevron Vision Program - VSP Vision Care (VSP)
Overview of Vision Benefits (VSP)

If you enroll in the Global Choice Plan, your benefit also automatically includes basic vision coverage provided by the Chevron Vision Program for you and your eligible dependents. VSP insures your basic vision benefits.

Basic Vision through VSP Vision Care (VSP)

<table>
<thead>
<tr>
<th></th>
<th>Global Choice Plan (U.S.-Payroll Expatriates)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network</td>
<td>100% of the comprehensive eye exam, including dilation as needed, per calendar year. Discounts on eyeglasses, contact lenses and accessories are available only from network providers.*</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>Up to $45 Maximum reimbursement per calendar year for a comprehensive eye exam, including dilation as needed.</td>
</tr>
</tbody>
</table>

* Additional coverage for vision materials (such as glasses and contacts) is available through the voluntary Vision Plus benefit. See the Vision Plus summary plan description for more information about enrollment and benefits.

**Important note: VSP does not have network providers outside the U.S. Services received outside the U.S. are considered out-of-network.**
Review the VSP Evidence of Coverage Document

VSP® Vision Care (VSP) is the insurer of the vision benefits provided through the Global Choice Plan. The benefits are governed by the insurance contracts with VSP and are described in the Evidence of Coverage. For a copy of the Evidence of Coverage contact:

- VSP at 1-800-877-7195 (inside the U.S.).

- If outside the U.S. and unable to access the toll-free number you may contact VSP by telephone at (916) 851-5000 (press “0” for operator assistance).

- Go to www.vsp.com/go/chevron on the Internet.
How to Use Your Basic Vision Benefit

To use your vision benefits in the U.S., tell your provider you have vision coverage with VSP. You can go to a provider in the VSP network or an out-of-network provider.

**Important note:** VSP does not have network providers outside the U.S. Services received outside the U.S. are considered out-of-network.

For the location of a network vision provider, to inquire about the cost to purchase lenses, frames or contact lenses or to locate a network provider for LASIK or PRK services, call VSP toll-free at 1-800-877-7195, Monday through Friday from 5 a.m. to 8 p.m. Pacific time, Saturday from 7 a.m. to 8 p.m. Pacific time, and Sunday from 7 a.m. to 7 p.m. Pacific time. If you’re outside the U.S. and you cannot access the toll-free number, contact VSP at 916-851-5000 (press “0” for operator assistance) Monday through Friday from 7 a.m. to 5 p.m. Pacific time. You can also access the VSP website at [www.vsp.com/go/chevron](http://www.vsp.com/go/chevron).
Basic Vision Claims

A participating network provider will submit claims automatically for you. If you go to an out-of-network provider, contact VSP at 1-800-877-7195 (or if outside the U.S. (916) 851-5000 and press “0” for operator assistance) to request information on how to get reimbursed for covered services. Claim forms are also available from the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.), or on the Benefits Connection website at hr2.chevron.com. If you have a dispute with VSP about a claim for benefits or to appeal a denied claim, you should follow VSP’s procedures to resolve your claim. Refer to your Evidence of Coverage for details. To obtain a copy of the Evidence of Coverage contact:

- VSP at 1-800-877-7195 (inside the U.S.).

- If outside the U.S. and unable to access the toll-free number you may contact VSP by telephone at (916) 851-5000 (press “0” for operator assistance).

- Go to www.vsp.com/go/chevron on the Internet.

You must file a claim for payment of benefits no later than 365 days from the date on which service was provided. If you don’t file a proper claim with VSP within this timeframe, benefits for service will be denied.

If your dispute concerns eligibility to participate in the plan, you must follow the procedures described in the How to File a Claim for Eligibility section.

Important note: VSP does not have network providers outside the U.S. Services received outside the U.S. are considered out-of-network.
Wellness Programs
Wellness Programs

The Omnibus Health Care Plan (which includes the Global Choice Plan) permits wellness programs to be offered under the terms and conditions established by Chevron. To learn about these wellness programs, see the Wellness Programs summary plan description.
Other Plan Information

- Administrative Information
- Your ERISA Rights
- Other Legislation That Can Affect Your Benefits
- Third Party Responsibility
Administrative Information

This section provides important legal and administrative information you may need regarding the benefits described in this book that are governed by the Employee Retirement Income Security Act of 1974 (ERISA).

Employer Identification Number (EIN)
The employer identification number for the health plans is 94-0890210.

Plan Sponsor and Plan Administrator
Chevron Corporation is the plan sponsor and administrator of the health plans and can be reached at the following address:

Chevron Corporation
P.O. Box 6075
San Ramon, CA 94583-0767
1-888-825-5247 (610-669-8595 outside the U.S.)

<table>
<thead>
<tr>
<th><strong>Chevron Global Choice Plan</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>This plan is part of the Omnibus Health Care Plan.</td>
</tr>
</tbody>
</table>

| **Plan number:** 560 |
| **Claims Administrator/Insurer:** Cigna (Group #05721A008) |
| For services outside the U.S.: Cigna ▐ P.O. Box 15050 ▐ Wilmington, DE 19850-5050 ▐ U.S.A. |
| For prescription drugs obtained outside the U.S.: Cigna ▐ P.O. Box 15050 ▐ Wilmington, DE 19850-5050 ▐ U.S.A. |
| For services inside the U.S.: Cigna ▐ P.O. Box 15050 ▐ Wilmington, DE 19850-5050 ▐ U.S.A. |
| **Type of Administration:** Insurer Administration |
| **Type of Plan:** Medical Benefit |

<table>
<thead>
<tr>
<th><strong>Chevron Corporation Prescription Drug Program</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>This program is part of the Global Choice and Omnibus Health Care Plan.</td>
</tr>
</tbody>
</table>

| **Plan number:** 560 |
| **Claims Administrator:** For prescription drugs obtained inside the U.S.: Express Scripts ▐ P.O. Box 2277 ▐ Lee’s Summit, MO 64063-2277  [www.Express-Scripts.com](http://www.Express-Scripts.com) |
| **Type of Administration:** Contract administration |
| **Type of Plan:** Medical (Prescription Drug) Benefit |
Chevron Corporation Vision Program
This program is part of the Global Choice and Omnibus Health Care Plan.

Plan number: 560
Insurer:
Out-of-network claims: P.O. Box 997105 | Sacramento, CA 95899-7105 www.vsp.com
Type of Administration: Insurer Administration
Type of Plan: Vision Benefit

Chevron Corporation Omnibus Health Care Plan

Plan number: 560
Type of Administration: Contract Administration
Type of Plan: Health Plan

Before-Tax Contribution Plan

Plan number: 721
Type of Administration: Company administered
Type of Plan: Health Contribution (Cafeteria Plan)

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

You can also serve process on a plan by serving the plan administrator. If you have a dispute with respect to medical benefits (inside or outside the US) or prescription drug benefits provided by the Global Choice Plan regarding benefits or claims, then any legal action should be directed to the agent for service of legal process appointed by Cigna.

For information about the procedure for a QMCSO, please contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).
Plan Amendments and Changes
Chevron Corporation reserves the right to change or terminate a plan at any time and for any reason. A change also can be made to premiums and future eligibility for coverage and can apply to those who retired in the past, as well as to those who retire in the future. Once approved, plan changes are incorporated into the plan texts, SPDs and vendor administration at the effective date.

Participating Companies
A complete list of the participating companies (designated by Chevron Corporation) whose employees are covered by each of the Chevron benefit plans can be obtained by writing to the plan administrator.

Collective Bargaining Agreements
If a union represents you, you’re eligible for the health care plans, provided both of the following apply:

- Your collective bargaining agreement allows for your participation.
- You meet the plans’ eligibility requirements.

Generally, Chevron’s collective bargaining agreements don’t mention specific plans or benefits. They merely provide that Chevron will extend to its employees who are members of the collective bargaining unit, the employee benefit programs that it generally makes available.

In some cases, however, a collective bargaining agreement contains more restrictive rules regarding participation or benefits than the rules described here. In such cases, the provisions of the collective bargaining agreement will prevail. For example, represented employees in a particular location might be able to enroll only in particular HMOs sponsored by the union.

A copy of any relevant collective bargaining agreement can be obtained by participants upon written request to their union representative.

All documents for this plan are available for examination by participants who follow the procedures outlined under Your ERISA Rights.

Incorrect Computation of Benefits
If you believe that the amount of the benefit you receive from the plans is incorrect, you should notify the appropriate claim administrator in writing.

If it’s found that you or a beneficiary wasn’t paid benefits you or your beneficiary was entitled to, the plan will pay the unpaid benefits.

Similarly, if the calculation of your or your beneficiary’s benefit results in an overpayment, you or your beneficiary will be required to repay the amount of the overpayment to the plan.

The claim administrator may make reasonable arrangements with you for repayment, such as reducing future benefits under the plan from which you received the overpayment.

Recovery of Overpayments
An overpayment is any payment made to you or your covered dependent (or elsewhere for the benefit of you or your covered dependent) in excess of the amount properly payable under the health plans. Upon any overpayment, the health plans shall have a first right of reimbursement and restitution with an equitable lien by contract in such amount. Furthermore, the holder of such overpayment shall hold it as the health plans’ constructive trustee.
If you or your covered dependent has cause to reasonably believe that an overpayment may have been made, you or your covered dependent must promptly notify the applicable claims administrator of the relevant facts. If the applicable claims administrator determines that an overpayment was made to you (or any other person), it will notify you in writing and you shall promptly pay (or cause another person to pay) the amount of such overpayment to the applicable claims administrator.

If the applicable claims administrator has made a written demand for the repayment of an overpayment and you (or another person) have not repaid (or caused to be repaid) the overpayment within 30 days following the date on which the demand was mailed, then any amounts subsequently payable as benefits under the health plans with respect to you or your covered dependent may be reduced by the amount of the outstanding overpayment, or the applicable claims administrator may recover such overpayment by any other appropriate method that the applicable claims administrator (or the Corporation) shall determine.

**Future of the Plans**

Chevron Corporation has the right to change or terminate a plan, including this Plan, at any time and for any reason. A change also may be made to premiums and future eligibility for coverage, and may apply to those who retired in the past, as well as those who retire in the future.

Medical claims incurred before the effective date of a plan change or termination won’t be affected. Claims incurred after a plan is terminated won’t be covered.

If a self-funded plan can’t pay all of the incurred claims and plan expenses as of the date the plan is changed or terminated, Chevron Corporation will make sufficient contributions to the self-funded plan to make up the difference.

If all claims and expenses are paid and Chevron Corporation’s book reserve established for the purpose of making contributions toward the cost of employees’ health care coverage retains a balance, Chevron Corporation will determine what to do with the excess amount in view of the purposes of the plans.

**No Right to Employment**

Nothing in your benefit plans gives you a right to remain in employment or affects Chevron’s right to terminate your employment at any time and for any reason (which right is hereby reserved).

**Plan Year**

The plan year for the health plans begins on January 1 and ends on December 31 of each year.

**Administrative Power and Responsibilities**

Chevron Corporation has the discretionary authority to control and manage the administration and operation of the Global Choice Plan (the “Plan”). Chevron Corporation shall have the full, exclusive and discretionary authority to prescribe such forms; make such rules, regulations, interpretations and computations; construe the terms of the Plan; determine all issues relating to coverage and eligibility for benefits; and take such other action to administer the Plan as it may deem appropriate in its sole discretion. Chevron Corporation’s rules, regulations, interpretations, computations and actions shall be final and binding on all persons. Such discretionary authority can also be exercised by a delegate.
Your ERISA Rights

The Employee Retirement Income Security Act of 1974 (ERISA) protects your benefit rights as an employee. It doesn’t require Chevron Corporation to provide a benefit plan; however, it does provide you with certain legal protections under the ERISA plans that Chevron Corporation does provide. This section summarizes these rights. In addition, you should be aware that Chevron Corporation reserves the right to change or terminate the plans at any time. Chevron Corporation will make every effort to communicate any changes to you in a timely manner.

As a participant in the Plan you’re entitled to certain rights and protections under ERISA.

Receive Information About Your Plan and Benefits
You have the right to:

• Examine (without charge), at the plan administrator’s office and at other specified locations such as work sites, all Plan documents. These may include insurance contracts, collective bargaining agreements, official Plan texts, trust agreements and copies of all documents, such as the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

• Obtain (by writing to the plan administrator) copies of all documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, copies of the latest Form 5500 annual report, and an updated SPD. The plan administrator can make a reasonable charge for the copies.

• Receive a summary of the Plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
You have a right to continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. For information regarding your continuation coverage rights, review the Continuation Coverage and COBRA Coverage section and the documents governing the plan.
If You Have a Pre-existing Condition
If you have creditable coverage from another plan, any exclusionary periods of coverage for pre-existing conditions under your group health plan may be reduced or eliminated. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when any of the following occurs:

- You lose coverage under the plan.
- You become entitled to elect continuation coverage.
- Your continuation coverage ceases.

You may request the certificate before losing coverage or up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. To request a certificate of creditable coverage, contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). Your personal identification number (PIN) will be required when making this request. Additionally, you can mail your request to the following address:

Chevron Corporation  
Human Resources Service Center  
P.O. Box 199708  
Dallas, TX 75219-9708

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon certain people who are responsible for the operation of Chevron Corporation’s plans. These people are called fiduciaries and have a duty to exercise fiduciary functions prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union or any other person, can fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your ERISA rights.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain (without charge) copies of documents related to the decision, and to appeal any denial — all within certain time schedules.
Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of the plan documents or the plan’s latest annual report and do not receive them within 30 days, you can file suit in a federal court. In such a case, the court can require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials — unless the materials were not sent because of reasons beyond the control of the plan administrator.

- If you disagree with the plan’s decision or lack of response to your request concerning the qualified status of a domestic relations order or medical child support order, you can file suit in a federal court.

- If you have a claim for benefits that is denied or ignored, in whole or in part, you can file suit in a state or federal court (see the Filing a Lawsuit section below).

- If it should happen that plan fiduciaries misuse the plan’s money, or if you’re discriminated against for asserting your ERISA rights, you can seek assistance from the U.S. Department of Labor or you can file suit in a federal court.

If you file suit, the court decides who should pay court costs and legal fees. If you’re successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees — for example, if it finds your claim is frivolous.

**Assistance With Your Questions**

If you have any questions about the plan, you should contact the claims administrator or plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You also can obtain certain publications about your rights and responsibilities under ERISA by:

- Calling the Employee Benefits Security Administration publications hotline at 1-866-444-3272.

Filing a Lawsuit
You can file a lawsuit to recover a benefit under a plan provided the action is commenced within the lesser of the applicable statute of limitations period or four years after the occurrence of the loss for which a claim is made. You can file a lawsuit to recover a benefit under a plan, provided all of the following have been completed:

• You initiate a claim as required by the plan.

• You receive a written denial of the claim.

• You file a timely written request for a review of the denied claim with the plan administrator or the claims administrator (or you receive written notification that the claim has been denied on appeal).

• If the plan provides for two levels of appeal, you file a timely written request for a second review of the denied claim with the plan administrator or the claims administrator (or you receive written notification that the claim has been denied on second appeal).

• If the plan provides for external review, you file a timely request for an external review of the denied claim with the plan administrator or the claims administrator.

• You receive written notification that the claim has been denied on final review.

If you want to take legal action after you exhaust the claims and appeals procedures, you can serve legal process on:

Service of Process
Chevron Corporation
6001 Bollinger Canyon Road
Building T (T-3371)
San Ramon, CA 94583

You also can serve process on a plan by serving the plan administrator. If you have a dispute with a health maintenance organization (HMO) or a dental health maintenance organization (DHMO) regarding benefits or claims, then any legal action should be directed to the agent for service of legal process appointed by the HMO or DHMO.

The plan administrator is the appropriate party to sue for all Chevron Corporation benefit plans.
Other Legislation That Can Affect Your Benefits

Over the years, several federal laws have been passed that can affect your benefits under certain circumstances.

**Newborns’ and Mothers’ Health Protection Act of 1996**
In accordance with the Newborns’ and Mothers’ Health Protection Act of 1996, the plan may not restrict benefits for a mother’s or newborn child’s hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, the law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable) following delivery.

**Reconstructive Surgery and Procedures**
Consistent with the Women’s Health and Cancer Rights Act of 1998, 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.

You may need to contact Cigna before any reconstructive surgery to make sure you qualify for full benefits.

**Health Insurance Portability and Accountability Act of 1996 (HIPAA)**
HIPAA was designed to make health care coverage easier to obtain for people who switch jobs or are between jobs. Companies are required to provide plan members with specific information about HIPAA when their medical coverage ends.

When you lose coverage under a Chevron medical plan, you automatically will be sent a certificate of creditable coverage. You may need to provide this certificate of creditable coverage to a new medical plan in which you enroll in order to reduce or eliminate the time period for which any pre-existing condition exclusions otherwise may apply. If you do not receive a certificate of creditable coverage within 10 days of the date your Chevron medical plan coverage terminates, you may contact Chevron’s HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.) to request a certificate of creditable coverage. Your personal identification number (PIN) will be required when making this request. Additionally, you can mail your request to the following address:

Chevron Corporation
Human Resources Service Center
P.O. Box 199708
Dallas, TX 75219-9708
Free or Low-Cost Health Coverage to Children and Families
Offered by Medicaid and the Children’s Health Insurance Program (CHIP)

If you are eligible for health coverage (medical, dental, vision) from Chevron or another employer, but you’re unable to afford the monthly premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance with paying their health premiums.

- **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 dependent(s) might be eligible for either of these programs, contact your state’s Medicaid or CHIP office. You can also call 1-877-KIDS NOW (1-877-543-7669) or visit [www.insurekidsnow.gov](http://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.

If it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, then 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 Human Resources (HR) Service Center and request Chevron health coverage within 60 days of being determined eligible for Medicaid or CHIP premium assistance.** If you enroll timely, Medicaid or CHIP will subsidize, or pay for, a portion of the Chevron health plan premium cost.

**If you have any questions**
Please call the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.) to speak with a Customer Service Representative. Customer Service Representatives are available from 6 a.m. to 5 p.m., Pacific time (8 a.m. to 7 p.m., Central time), Monday through Friday, except on holidays.
If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2013. You should contact your State for further information on eligibility.

<table>
<thead>
<tr>
<th>State</th>
<th>Eligibility</th>
<th>Website</th>
<th>Phone</th>
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<tbody>
<tr>
<td>ALASKA</td>
<td>Medicaid</td>
<td><a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">http://health.hss.state.ak.us/dpa/programs/medicaid/</a></td>
<td>1-888-318-8890 (Outside of Anchorage)</td>
</tr>
<tr>
<td>ARIZONA</td>
<td>CHIP</td>
<td><a href="http://www.azahcccs.gov/applicants">http://www.azahcccs.gov/applicants</a></td>
<td>1-877-764-5437 (Outside of Maricopa County)</td>
</tr>
<tr>
<td>IDAHO</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.accessstothelifeinsurance.idaho.gov">www.accessstothelifeinsurance.idaho.gov</a></td>
<td>1-800-926-2588 (Medicaid Phone)</td>
</tr>
<tr>
<td>IOWA</td>
<td>Medicaid</td>
<td><a href="http://www.dhs.state.ia.us/hipp/">www.dhs.state.ia.us/hipp/</a></td>
<td>1-888-346-9562 (In state)</td>
</tr>
<tr>
<td>KENTUCKY</td>
<td>Medicaid</td>
<td><a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a></td>
<td>1-800-635-2570 (In state)</td>
</tr>
<tr>
<td>COLORADO</td>
<td>Medicaid</td>
<td><a href="http://www.colorado.gov/">http://www.colorado.gov/</a></td>
<td>1-800-866-3513 (Medicaid Phone)</td>
</tr>
<tr>
<td>GEORGIA</td>
<td>Medicaid</td>
<td><a href="http://dch.georgia.gov/">http://dch.georgia.gov/</a></td>
<td>Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)</td>
</tr>
<tr>
<td>MONTANA</td>
<td>Medicaid</td>
<td><a href="http://dwss.nv.gov">http://dwss.nv.gov</a></td>
<td>1-800-992-0900 (Medicaid Phone)</td>
</tr>
<tr>
<td>NEBRASKA</td>
<td>Medicaid</td>
<td><a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a></td>
<td>1-800-383-4278 (In state)</td>
</tr>
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</table>

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<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone</th>
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<tbody>
<tr>
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<tr>
<td><strong>MASSACHUSETTS</strong></td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a></td>
<td>1-800-462-1120</td>
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<tr>
<td><strong>MINNESOTA</strong></td>
<td>Medicaid</td>
<td><a href="http://www.dhs.state.mn.us/">http://www.dhs.state.mn.us/</a> Click on Health Care, then Medical Assistance</td>
<td>1-800-657-3629</td>
</tr>
<tr>
<td><strong>MISSOURI</strong></td>
<td>Medicaid</td>
<td><a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a></td>
<td>573-751-2005</td>
</tr>
<tr>
<td><strong>OKLAHOMA</strong></td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
<td>1-888-365-3742</td>
</tr>
<tr>
<td><strong>OREGON</strong></td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.oregonhealthykids.gov">http://www.oregonhealthykids.gov</a></td>
<td>1-800-699-9075</td>
</tr>
<tr>
<td><strong>PENNNSYLVANIA</strong></td>
<td>Medicaid</td>
<td><a href="http://www.dpw.state.pa.us/hipp">http://www.dpw.state.pa.us/hipp</a></td>
<td>1-800-692-7462</td>
</tr>
<tr>
<td><strong>NEW JERSEY</strong></td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a></td>
<td>609-631-2392</td>
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<tr>
<td><strong>NEW YORK</strong></td>
<td>Medicaid</td>
<td><a href="http://www.nyhealth.gov/health_care/medicaid/">http://www.nyhealth.gov/health_care/medicaid/</a></td>
<td>1-800-541-2831</td>
</tr>
<tr>
<td><strong>NORTH CAROLINA</strong></td>
<td>Medicaid</td>
<td><a href="http://www.ncdhhs.gov/dma">http://www.ncdhhs.gov/dma</a></td>
<td>919-855-4100</td>
</tr>
<tr>
<td><strong>NORTH DAKOTA</strong></td>
<td>Medicaid</td>
<td><a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a></td>
<td>1-800-755-2604</td>
</tr>
<tr>
<td><strong>VERMONT</strong></td>
<td>Medicaid</td>
<td><a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
<td>1-800-250-8427</td>
</tr>
</tbody>
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Chevron Corporation
Summary Plan Description
Effective January 1, 2014

Global Choice Plan (U.S.-Payroll Expatriates) | Page 106
<table>
<thead>
<tr>
<th>RHODE ISLAND – Medicaid</th>
<th>WASHINGTON – Medicaid</th>
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<tbody>
<tr>
<td>Website: <a href="http://www.ohhs.ri.gov">www.ohhs.ri.gov</a></td>
<td>Website: <a href="http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm">http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm</a></td>
</tr>
<tr>
<td>Phone: 401-462-5300</td>
<td>Phone: 1-800-562-3022 ext. 15473</td>
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<tr>
<th>SOUTH CAROLINA – Medicaid</th>
<th>WEST VIRGINIA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website: <a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a></td>
<td>Website: <a href="http://www.dhhr.wv.gov/bms/">www.dhhr.wv.gov/bms/</a></td>
</tr>
<tr>
<td>Phone: 1-888-549-0820</td>
<td>Phone: 1-877-598-5820, HMS Third Party Liability</td>
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<tr>
<th>SOUTH DAKOTA – Medicaid</th>
<th>WISCONSIN – Medicaid</th>
</tr>
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<tbody>
<tr>
<td>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a></td>
<td>Website: <a href="http://www.badgercareplus.org/pubs/p-10095.htm">http://www.badgercareplus.org/pubs/p-10095.htm</a></td>
</tr>
<tr>
<td>Phone: 1-888-828-0059</td>
<td>Phone: 1-800-362-3002</td>
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<tr>
<th>TEXAS – Medicaid</th>
<th>WYOMING – Medicaid</th>
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<tr>
<td>Website: <a href="https://www.gethipptexas.com/">https://www.gethipptexas.com/</a></td>
<td>Website: <a href="http://health.wyo.gov/healthcarefin/equalitycare">http://health.wyo.gov/healthcarefin/equalitycare</a></td>
</tr>
<tr>
<td>Phone: 1-800-440-0493</td>
<td>Phone: 307-777-7531</td>
</tr>
</tbody>
</table>

To see if any more States have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor  U.S. Department of Health and Human Services
Employee Benefits Security Administration  Centers for Medicare & Medicaid Services
1-866-444-EBSA (3272)  1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)
Third Party Responsibility

Payment of Certain Benefits Subject to Full Right to Subrogation and Reimbursement
If you or your covered dependent receives benefits under any of the health plans related to injuries, illnesses or conditions resulting from the act or omission of any third person, or related to any matter reimbursable under a contract of no-fault automobile insurance, you agree that the health plans retain full rights of subrogation, reimbursement and restitution for the payment of such benefits. This means that if you or your covered dependent recovers payment from any third party (including another insurance provider) as a result of the event that caused a benefit to be paid under any of the health plans, you or your covered dependent will be required to repay the expenses incurred by that health plan.

If, as a result of someone else’s actions or omissions, you seek care which requires payment under the health plans, you should inform the applicable claims administrator of this as soon as possible. It is your responsibility, as a condition of participation in the health plans, that you inform the health plans of someone else’s liability for your injuries, illnesses or conditions.

First Right of Recovery
As a condition of receiving benefits under the health plans, you or your covered dependent grants specific and first rights of subrogation, reimbursement and restitution to the health plans. This means that you agree to repay the health plans first, before paying any other creditors or otherwise disposing of any settlement that you receive related to the event that caused benefits to be paid under the health plans. The right of the health plans to recover is not diminished by how such recovery may be itemized, structured, allocated, denominated or characterized (for example, whether your recovery is characterized as for lost wages or damages, rather than for medical expenses).

These rights extend to any property (including money) that is directly or indirectly related to the health plans’ benefits that were paid. These rights are not affected by the type of property or the source or amount of the recovery, including, but not limited to, any recovery from the payment or compromise of a claim (including an insurance claim), a judgment or settlement of a lawsuit, resolution through any alternative dispute resolution process (including arbitration), or any insurance (including insurance on you or your covered dependent, no-fault coverage, and uninsured or underinsured motorist coverage).

Furthermore, the health plans’ rights to reimbursement, restitution, to an equitable lien by contract, and as beneficiary of a constructive trust shall in no way be affected, reduced, compromised, or eliminated by any state law, common law, or equitable doctrines limiting its rights, including, but not limited to, the make-whole doctrine, common fund doctrine, comparative fault rule, contributory negligence rule, unjust enrichment doctrine, or any similar doctrine or rule established by common law or by statute, or any other defense which may act to reduce the amount the health plans’ may be entitled to recover.
Granting of an Equitable Lien by Contract
At the time the health plans pay benefits, you or your covered dependent grants to the health plans (as a condition of such payment) an equitable lien by contract in any property described above. This means that you grant the health plans a first right to any property (including money) that you recover as a result of the event that caused the benefits to be paid. This right to an equitable lien by contract exists without regard to the identity of the property’s source or holder at any particular time, or whether at any particular time the property exists, is segregated, or you or your covered dependent has any rights to it.

Creation of Constructive Trust
You or your covered dependent agrees that until such equitable lien by contract is completely satisfied (that is, the health plans are reimbursed in full), the holder of any such property (whether you or your covered dependent, you or your covered dependent's attorney, an account or trust set up for you or your covered dependent’s benefit, an insurer, or any other holder) shall hold such property as the Omnibus Health Care Plan's constructive trustee. The constructive trustee agrees to immediately pay over such property to or on behalf of the health plans, pursuant to their direction, to the extent necessary to satisfy the equitable lien by contract.

Your Responsibilities
As a condition of receiving benefits under the health plans, you or your covered dependent agrees:

- Not to assign any rights or causes of action you may have against others (including under insurance policies) without the express written consent of the health plans.

- To take possession of any property subject to the health plans’ equitable lien by contract in your own name, place it in a segregated account within your control (at least in the amount of the equitable lien by contract), and not to alienate it or otherwise take any action so that it is not in your possession prior to the satisfaction of such equitable lien by contract.

- That if such property is not in your possession (other than in possession by or on behalf of the health plans), to immediately take whatever steps possible to regain possession or have possession transferred to or on behalf of the health plans pursuant to their direction.

- To cooperate with the health plans and take any action that may be necessary to protect the health plans’ right to recovery.
Your Notice Obligations
You or your covered dependent agrees to timely notify the health plans of:

- The possibility that benefits paid by the health plans may be the responsibility of a third party.
- The submission of any claim or demand letter, the filing of any legal action, the request for any alternative dispute resolution process, or the commencement date of any trial or alternative dispute resolution process, regarding or related to any property that may be subject to the health plans’ rights (1) of subrogation, reimbursement and restitution, (2) to an equitable lien by contract, and (3) as beneficiary of a constructive trust.
- Any agreement that any property that may be subject to the health plans’ rights (1) of subrogation, reimbursement and restitution, (2) to an equitable lien by contract, and (3) as beneficiary of a constructive trust will be paid to or on behalf of you or your covered dependent (whether pursuant to resolution of a claim, legal action, alternative dispute resolution proceeding, or otherwise).

Timely notice is notice that provides the health plans with sufficient time to protect their own rights to subrogation, reimbursement and restitution; to an equitable lien by contract; and as beneficiary of a constructive trust. Notice of the commencement date of any trial or alternative dispute resolution process must be given at least 30 days in advance.

No Duty to Independently Sue or Intervene
Although the health plans’ subrogation rights include the right to file an independent legal action or alternative dispute resolution proceeding against such third party (or to intervene in one brought by or on behalf of you or your covered dependent), the health plans have no obligation to do so.

Recovery of Overpayments
An overpayment is any payment made to you or your covered dependent (or elsewhere for the benefit of you or your covered dependent) in excess of the amount properly payable under the health plans. Upon any overpayment, the health plans shall have a first right of reimbursement and restitution with an equitable lien by contract in such amount.

Furthermore, the holder of such overpayment shall hold it as the health plans’ constructive trustee.

If you or your covered dependent has cause to reasonably believe that an overpayment may have been made, you or your covered dependent must promptly notify the applicable claims administrator of the relevant facts. If the applicable claims administrator determines that an overpayment was made to you (or any other person), it will notify you in writing and you shall promptly pay (or cause another person to pay) the amount of such overpayment to the applicable claims administrator.

If the applicable claims administrator has made a written demand for the repayment of an overpayment and you (or another person) have not repaid (or caused to be repaid) the overpayment within 30 days following the date on which the demand was mailed, then any amounts subsequently payable as benefits under the health plans with respect to you or your covered dependent may be reduced by the amount of the outstanding overpayment, or the applicable claims administrator may recover such overpayment by any other appropriate method that the applicable claims administrator (or the Corporation) shall determine.
Continuation Coverage and COBRA Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that entitles you and your eligible dependents to continue health plan coverage for a period of time after it would otherwise end. Read this section for:

- Important information about your right to continuation coverage.
- An explanation of when continuation coverage may become available.
- A description of what you need to do to protect your right to receive continuation coverage.
Introduction

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that entitles you and your eligible dependents to continue health plan coverage for a period of time after it would otherwise end. This continuation coverage becomes available when a qualifying event occurs. If you or your dependents decline this coverage when first eligible for it, you waive the right to enroll at a later date, except that you or your dependents may enroll at any time during the initial period of eligibility, even if you have previously declined coverage. This section:

- Contains important information about your right to continuation coverage.
- Explains when continuation coverage may become available.
- Describes what you need to do to protect your right to receive continuation coverage.

Pursuant to Chevron policy, your domestic partner and any of your domestic partner’s dependent children who are covered by a Chevron health plan on the day before a qualifying event occurs are also eligible for continuation coverage that is similar to COBRA.

What Is Continuation Coverage?
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health coverage (called COBRA continuation coverage) at group rates when there is a qualifying event where coverage would otherwise end. (Specific qualifying events are listed later in this section.) After a qualifying event, continuation coverage must be offered to each qualified beneficiary.

You, your spouse and your dependent children could become qualified beneficiaries if coverage under a Chevron health plan is lost because of the qualifying event. Qualified beneficiaries also include any children born to you or adopted or placed for adoption with you during the continuation coverage period. Pursuant to Chevron policy, domestic partners and domestic partner dependent children who are covered under a Chevron health plan on the day before a qualifying event are also permitted to elect continuation coverage that is similar to COBRA.

You do not have to show that you are insurable to choose continuation coverage. However, you will have to pay the total premium for your continuation coverage, plus a 2 percent administration fee.

Conversion Coverage
If you are enrolled in an insured plan or HMO and you elect continuation coverage, you may have an option to convert your health coverage to an individual policy at the termination of your continuation coverage. Contact your insurer or HMO for additional information about any conversion rights you may have. There are no conversion rights for dental coverage, mental health and substance abuse coverage, the Healthy Heart Program, Health Decision Support, or Executive Physical Program.
Who’s Eligible for Continuation Coverage

Under COBRA and pursuant to Chevron policy, you, your spouse, your domestic partner and your eligible dependent children are eligible to enroll for continuation coverage under a Chevron health plan if they are enrolled in the plan on the day before a qualifying event occurs.

If you acquire a new dependent through birth, adoption or placement for adoption while you are receiving continuation coverage, that new dependent will also be considered a qualified beneficiary as long as he or she is timely enrolled in a Chevron health plan. If you otherwise acquire a new eligible dependent after your continuation coverage begins, you can enroll him or her for continuation coverage but the new dependent will not be considered a qualified beneficiary. If your former spouse/domestic partner or dependent child acquires a new eligible dependent after continuation coverage begins, he or she can enroll the new dependent for continuation coverage but the newly enrolled dependent will not be considered a qualified beneficiary.

Your spouse and dependent children may also be eligible for continuation coverage if it’s determined that you canceled their regular health plan coverage to prevent them from qualifying for continuation coverage (in anticipation of your divorce, for example). In this situation, your spouse and dependent children must notify Chevron within 60 days if you’re divorced or if an enrolled child no longer satisfies the eligibility requirements for regular health plan coverage. Please see the section titled Eligible Children and Other Dependents for details on eligibility. Your domestic partner and dependent children must notify Chevron within 31 days if your domestic partnership ends. If your spouse/domestic partner and dependent children do not notify Chevron within the above time limits, they will become permanently ineligible for future continuation coverage as a result of that qualifying event.
Qualifying Events

You become a qualified beneficiary and can enroll in continuation coverage if your Chevron health plan coverage ends because of one of the following qualifying events:

- Your Chevron employment ends for any reason other than termination for gross misconduct.
- You’re on a Personal Leave Without Pay, Leave for Educational Reasons or Long Union Business Leave that’s scheduled to last more than 31 days.
- Your work hours are reduced and you’re no longer eligible for Chevron health care benefits.

Note that a termination of employment following a reduction of hours will not be considered a qualifying event if you became ineligible for Chevron health care coverage as a result of a reduction in hours.

Your enrolled spouse/domestic partner and dependent children have the right to elect continuation coverage if their Chevron health plan coverage ends because of one of the following events:

- Your Chevron employment ends for any reason other than termination for gross misconduct.
- You’re on a Personal Leave Without Pay, Leave for Educational Reasons or Long Union Business Leave that’s scheduled to last more than 31 days.
- Your work hours are reduced and you’re no longer eligible for Chevron health care benefits.
- You die.
- Your spouse/domestic partner or enrolled child or other dependent no longer meets the Chevron health plans’ eligibility requirements.
- You and your spouse get a divorce.
- You are the spouse of a member and your group health coverage is reduced or eliminated in anticipation of a divorce and a divorce later occurs.
- You and your domestic partner end your domestic partnership.

Special Rule for Bankruptcy of the Employer

Pursuant to COBRA, sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy were to be filed with respect to Chevron, and that bankruptcy resulted in the loss of coverage of any retired employee covered under a Chevron health plan, the retired employee would become a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse/domestic partner, surviving spouse/domestic partner and dependent children would also become qualified beneficiaries if such bankruptcy results in the loss of their coverage under a Chevron health plan.
How to Enroll

Chevron Must Give Notice of Some Events
Chevron has the responsibility to notify ADP Benefit Services, which handles Chevron’s continuation coverage administration, when any of the following occurs:

- Your Chevron employment ends for any reason other than termination for gross misconduct.
- You’re on a Personal Leave Without Pay, Leave for Educational Reasons or Long Union Business Leave that’s scheduled to last more than 31 days.
- Your work hours are reduced and you’re no longer eligible for Chevron health care benefits.
- You die while actively employed.

You Must Give Notice of Some Events
You must notify Chevron within 60 days after the first of the month coinciding with or following your divorce, or if an enrolled child no longer satisfies the eligibility requirements for regular health plan coverage. Please see the section titled Eligible Children and Other Dependents for details on eligibility. You must notify Chevron within 31 days after the first of the month coinciding with or following the termination of your domestic partnership or any final determination by the Social Security Administration that a qualified beneficiary is disabled or is no longer disabled. If you don’t notify Chevron within the above time limits, your dependents won’t be eligible for continuation coverage.

You must also notify Chevron within 31 days if, after electing continuation coverage, you become covered by another group health plan or enroll in Medicare Part A, Part B or both.

The following information should be included in the notice:

- The name of the individual experiencing the qualifying event (the qualified beneficiary).
- The name and Social Security number of the employee or former employee.
- The type of qualifying event.
- The date of the qualifying event.
- The address of the qualified beneficiary.
- A copy of the Notice of Award letter from the Social Security Administration, if applicable.

Chevron may also require you to provide documentation of a qualifying event, such as a final divorce decree, before continuation coverage is offered.

You should provide your notice to the Chevron HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). Your personal identification number (PIN) will be required when reporting the event by telephone. Additionally, you can mail your notice to the following address:
If you or a family member does not provide this notice to Chevron's HR Service Center within the time limit specified above, you and your dependents will lose eligibility for continuation coverage with respect to that qualifying event.

Also, if while you are receiving continuation coverage you acquire a new dependent as a result of birth, adoption or placement for adoption, you must enroll your new dependent with the HR Service Center within 31 days of acquiring the new dependent. If you fail to do so, your new dependent will not be considered a qualified beneficiary for purposes of continuation coverage and may not be covered under a Chevron health plan until a subsequent annual open enrollment period, if applicable.

**Electing Continuation Coverage**
When ADP Benefit Services is notified by the HR Service Center that one of these events has occurred, ADP Benefit Services will in turn notify you that you have the right to elect continuation coverage. Under the law, you have 60 days from the date you would lose Chevron health plan coverage because of one of these events, or the date your continuation coverage election notice is sent to you, whichever is later, to inform ADP Benefit Services that you want continuation coverage.

Each qualified beneficiary has an independent right to elect continuation coverage. Covered employees can elect continuation coverage on behalf of their spouses/domestic partners, and parents can elect continuation coverage on behalf of their dependent children.

You or your eligible dependents must complete and return the continuation coverage election form within 60 days after Chevron health plan coverage would otherwise end or, if later, within 60 days after the date your continuation coverage election notice is sent to you. If you do not choose continuation coverage during the election period, your Chevron health plan coverage will end the last day of the month in which your employment ends.

If you or your dependent elects continuation coverage within this 60-day period, upon timely receipt of the full amount of the first required premium payment for continuation coverage, your or your dependent’s Chevron health plan coverage will be reinstated retroactive to the date Chevron health plan coverage ended.

**Keep the Plan Informed of Address Changes**
In order to protect your family’s rights, you should keep Chevron informed of any changes in the addresses of family members by contacting the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). You should also keep a copy, for your records, of any notices you send to the HR Service Center.
How Much Continuation Coverage Costs

In most cases, you or your dependents pay 100 percent, plus a 2 percent administrative fee, of the cost of health plan coverage that’s continued. The cost of coverage will vary based on the plans you’re enrolled in and how many family members are enrolled. (If you’re eligible for continuation coverage because you’re on a Long Union Business Leave that’s scheduled to last more than 31 days, you’re not required to pay the 2 percent administrative fee.) If you or your dependents are eligible for the 11-month disability extension and the disabled qualified beneficiary elects continuation coverage, you or your dependents will pay 150 percent of the cost of health plan coverage that’s continued for months 19 through 29.

You or your dependents must pay Chevron for this coverage as long as it’s in effect. Your first payment for continuation coverage is due within 45 days after the date of your election. (This is the date the continuation coverage election form is postmarked, if mailed.) If you do not make your first premium payment for continued coverage within 45 days, you will lose all continuation coverage rights under the plan.

After that, payments are due on the first day of each month. For example, payment for January coverage is due on January 1. Coverage will be canceled and can’t be reinstated if a payment is 30 days overdue. It is the qualified beneficiary’s responsibility to make timely payments, even if he or she does not receive a payment coupon.

Regular monthly COBRA payments should be mailed to:

ADP Benefit Services – COBRA
P.O. Box 7247-0367
Philadelphia, PA 19170-0367

Or via overnight to:

ADP Benefit Services – COBRA Lockbox 0367
c/o Citibank Lockbox Operations
1615 Brett Road
New Castle, DE 19720-2425
When Continuation Coverage Starts

Your regular health plan coverage will end on the last day of the month in which a qualifying event occurs. If you or your dependents enroll for continuation coverage within 60 days after regular coverage ends (or, if later, within 60 days after the date the continuation coverage election notice is sent to you) upon timely receipt of the full amount of the required first payment for continuation coverage, your or your dependent’s Chevron health plan coverage will be reinstated retroactive to the date Chevron health plan coverage ended. If you fail to meet these deadlines, you or your dependents will waive the right to enroll for continuation coverage.

How Long Continuation Coverage Lasts

You, your spouse, your domestic partner and your covered dependents may qualify for up to 18 months of health care continuation coverage if you qualify due to one of the following qualifying events:

- Your Chevron employment ends for any reason other than termination for gross misconduct.
- You’re on a Personal Leave Without Pay, Leave for Educational Reasons or Long Union Business Leave that’s scheduled to last more than 31 days.
- Your work hours are reduced and you’re no longer eligible for Chevron health care benefits.

Your covered spouse, your domestic partner and your covered dependents may qualify for up to 36 months of health care continuation coverage if they qualify due to one of the following qualifying events:

- You die.
- An enrolled child or other dependent no longer meets the Chevron health plans’ eligibility requirements.
- You and your spouse get a divorce.
- You and your domestic partner end your domestic partnership.

Your survivor and his or her covered dependents may qualify for up to 36 months of health care continuation coverage when:

- Your survivor’s Chevron retiree and survivor coverage ends because your survivor adds a new spouse or another dependent to health coverage.

Continuation coverage generally lasts for up to a total of 18 months when the qualifying event is the end of employment or reduction of the employee’s hours of employment. This 18-month period of continuation coverage can be extended in two ways: disability extension or second qualifying event extension.
Disability extension of 18-month period of continuation coverage
The 18-month period may be extended for you and your covered family members if the Social Security Administration determines that you or another family member who is a qualified beneficiary is disabled at any time during the first 60 days of continuation coverage. Coverage for all family members who are qualified beneficiaries, as a result of the same qualifying event, can be extended for up to an additional 11 months (for a total of 29 months) if all of the following requirements are met:

- Your continuation coverage qualifying event was an employee’s termination of employment (for any reason other than gross misconduct) or a reduction in hours so that the employee (and you) was no longer eligible for Chevron health care benefits.

- The disability started at some time before the 60th day of continuation coverage and lasts at least until the end of the 18-month period of continuation coverage.

- A copy of the Notice of Award from the Social Security Administration is provided to the HR Service Center within 60 days of receipt of the notice and before the end of the initial 18 months of continuation coverage.

- If the disabled qualified beneficiary elects continuation coverage, you must pay an increased premium of 150 percent of the monthly cost of health plan coverage that’s continued, beginning with the 19th month of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If another qualifying event occurs during the first 18 months of continuation coverage, your spouse/domestic partner and dependent children can receive up to an additional 18 months of continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is timely provided to the HR Service Center as described in You Must Give Notice of Some Events under How to Enroll in this Continuation Coverage and COBRA Coverage section.

This extension may be available to your spouse/domestic partner and any dependent children receiving continuation coverage if you die, get divorced or terminate your domestic partner relationship or if your dependent child is no longer eligible under the terms of a Chevron health plan as a dependent child. A second event will be considered a qualifying event only if the second event would have caused your spouse/domestic partner or dependent child to lose coverage under the health plan had the first qualifying event not occurred.

Extension Due to Medicare Eligibility
When the qualifying event is the end of employment (for reasons other than gross misconduct) or reduction of the employee’s hours of employment, and the employee became entitled to Medicare (Part A, Part B or both) benefits within 18 months prior to the qualifying event, continuation coverage for qualified beneficiaries (other than the employee) can last until 36 months after the date of Medicare entitlement. In order to qualify for this extension, you must provide the HR Service Center with a copy of your Medicare card showing the date of Medicare entitlement.

In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect continuation coverage.
When Continuation Coverage Ends

Continuation coverage may be terminated before the maximum period if one of the following occurs:

- The premium for your continuation coverage is not paid on time.

- If after electing continuation coverage, you become covered by another group health plan, unless the plan contains any exclusions or limitations with respect to any pre-existing condition you or your covered dependents may have.

- If after electing continuation coverage, you first become eligible for and enroll in Medicare Part A, Part B or both.

- You extend coverage for up to 29 months due to a qualified beneficiary’s disability and there has been a final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. In this case, continuation coverage will end on the first of the month that begins more than 30 days after the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. This will be the case only if the qualified beneficiary has been covered by continuation coverage for at least 18 months.

- Chevron no longer provides group health coverage to any of its eligible employees or eligible retirees.

Continuation coverage also may be terminated early for any reason the Chevron health plans would terminate coverage of a participant or beneficiary not receiving continuation coverage (for example, if you commit fraud or make an intentional misrepresentation of a material fact).
Continuation Coverage vs. Retiree and Survivor Coverage

If you qualify as an eligible retiree at the time of your termination of employment with Chevron, you will have the option to elect either one of the following for you and your covered dependents:

- Retiree and survivor coverage.
- Continuation coverage.

The costs for retiree and survivor coverage and continuation coverage may differ. You should carefully review the information provided to you by Chevron at the time you terminate employment with Chevron.

Although you have the option to elect either retiree and survivor coverage, or continuation coverage, generally, if you don’t enroll in retiree and survivor coverage when you first become eligible, then you can only elect retiree and survivor coverage during an annual open enrollment period. However, there are a few exceptions as follows:

- This provision does not apply if you were a former employee who was eligible for both subsidized COBRA and retiree medical coverage and initially elected subsidized COBRA coverage. In this case you can immediately enroll in retiree medical coverage after your subsidized COBRA coverage ends, provided you do so within 31 days of the subsidized COBRA coverage ending.
- This provision does not apply if you and your dependents are covered by another Group Plan upon your death. In this case, your survivors are able to elect coverage under the retiree and survivor plan, provided they do so within 31 days of your death.

Elections you make during an open enrollment period will become effective at the beginning of the next calendar year, unless you have a qualifying life event (for example, you get married or divorced) that is subject to midyear special enrollment rights.
Continuation Coverage Considerations

If you don’t elect continuation coverage …
If you qualify as an eligible retiree and don’t elect continuation coverage, you and your eligible dependents that were enrolled in a Chevron health plan on the day before the qualifying event will be automatically enrolled in retiree and survivor coverage with Chevron. Retiree and survivor coverage will be effective retroactively to the first day of the month following your termination of employment. You may still elect continuation coverage during the 60-day election period. If you elect continuation coverage after you have been automatically enrolled in retiree and survivor coverage, your retiree and survivor coverage will be retroactively canceled.

If you elect continuation coverage …
If you qualify as an eligible retiree at the time of your termination of employment with Chevron and you elect continuation coverage, you may enroll in retiree and survivor coverage at a later time, but only during an annual open enrollment period. However, there are a few exceptions that apply – please see above.

Special exceptions if you are eligible for subsidized COBRA …
If you are eligible for both retiree medical coverage and subsidized COBRA and you initially elect subsidized COBRA coverage, some of the provisions above do not apply to you:

- You can immediately enroll in retiree and survivor coverage after your subsidized COBRA coverage has ended, as long as you do so within 31 days of the subsidized coverage ending. You do not have to wait for an open enrollment period.
- If you die while enrolled in subsidized COBRA, your survivors can immediately enroll in retiree and survivor coverage after subsidized COBRA coverage has ended, as long as they do so within 31 days of the subsidized coverage ending.
- If you die while enrolled in another employer’s group health plan, your survivors can immediately enroll in retiree and survivor coverage after your death, as long as they do so within 31 days of your death.
Retiree and Survivor Coverage Considerations
If you die, your enrolled dependents are eligible for either continuation coverage (described under Continuation Coverage and COBRA Coverage in this section) or survivor coverage under Chevron’s health plans. Chevron currently pays a portion of the cost for survivor coverage. However, if your enrolled dependent(s) elect continuation coverage, they must pay the entire cost plus a 2 percent administrative fee.

Your enrolled dependents may elect survivor coverage within 31 days of your death. Upon timely receipt of any required premiums, an election of survivor coverage will be effective retroactive to the day after the day that the survivor’s (and his or her covered dependent(s), if applicable) coverage under Chevron’s health plans terminates. In the event that such survivor subsequently elects continuation coverage within the election period, such survivor’s (and his or her eligible dependent(s), if applicable) survivor coverage shall be canceled retroactive to the day it commenced.

Survivor coverage for your spouse/domestic partner can continue until he or she dies, cancels survivor coverage or does not make timely premium payments. Survivor coverage can continue if a surviving spouse/domestic partner remarries or enters into a new domestic partner relationship, but the new spouse/domestic partner or any other dependents cannot be added to any Chevron health plan. If your spouse wishes to add his or her new spouse or other dependent to the plan, survivor coverage ends, and up to 36 months of continuation coverage becomes available.

Survivor coverage for your enrolled children can continue until the child reaches age 26 (unless incapacitated), or is no longer eligible according to the eligibility provisions for the health plans for reasons other than your death. Please see the Eligible Children and Other Dependents section for details on eligibility. If your dependent wishes to add his or her new spouse or other dependent to the plan, survivor coverage ends, and up to 36 months of continuation coverage becomes available.

Survivor coverage will also end early if the survivor fails to timely pay any required premiums for coverage or as of the date the survivor has received the maximum benefit under a particular Chevron health plan. Survivor coverage will also end if Chevron ceases to provide any health plan for any of its employees or retirees. Survivor coverage may also be terminated due to fraud or intentional misrepresentation of a material fact.

If your covered spouse or covered child becomes ineligible for survivor coverage, he or she can continue Chevron health plan coverage for up to 36 months under the terms of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Pursuant to Chevron policy, your covered domestic partner and your domestic partner’s covered dependent children may also be eligible for continuation coverage that’s similar to COBRA if they become ineligible for survivor coverage under the Chevron health plans.

If a surviving spouse/surviving domestic partner or surviving dependent child waives all health plan coverage, they become permanently ineligible for future Chevron health plan coverage with respect to your death.
Additional Rights and Rules

Special Rule:
Periods of Continuation Coverage Subject to the Uniformed Services Employment and Reemployment Rights Act of 1994
If you are on a Military Service Leave, you will be permitted to continue health plan coverage for you, your spouse and your dependent children in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and pursuant to Chevron policy.

While you are on a Military Service Leave, your health plan coverage may continue. Chevron will continue to pay its normal company contribution, provided that you continue to timely pay your required employee contributions. While you are on paid status, your employee contribution will be deducted from your paycheck, provided that you have sufficient funds available after required deductions. If your employee contribution exceeds the amount of pay available, or if you are on unpaid status, you will receive a bill from Chevron’s HR Service Center for your health plan coverage.

It is your responsibility to make timely payments for your regular benefits coverage as defined by the administrative rules of the Omnibus Health Care Plan. If the full premium payment is not received by the payment due date, your regular benefits coverage will be terminated retroactive to the end of the month for which full payment was received. If you have been on Military Service Leave for less than 24 months at the time your regular coverage ends, you will be offered continuation coverage (under USERRA).

Your, your spouse’s or your dependent’s period of continuation coverage under USERRA will begin on the date your Military Service Leave begins and will end on the earliest of the following dates:

- The 24-month period beginning on the date on which your Military Service Leave begins.
- The period ending on the day after the date on which you fail to timely apply for or return to a position of employment with Chevron, as determined under section 4312(e) of USERRA.

Periods of continuation coverage offered in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) will run concurrently with periods of continuation coverage offered pursuant to COBRA and Chevron policy.

You are covered under USERRA if you serve voluntarily or involuntarily as a member of the uniformed services of the United States, including serving in the reserves or as designated by the president. The uniformed services include the U.S. Army, Navy, Marines, Air Force and Coast Guard, and the Public Health Service Commissioned Corps.

How Much USERRA Continuation Coverage Costs
If you fail to pay your employee contributions such that you are no longer eligible for regular coverage and you elect USERRA continuation coverage, you must pay 100 percent, plus a 2 percent administrative fee, of the cost of health plan coverage that’s continued. The cost of coverage will vary based on the plans you’re enrolled in and how many family members are enrolled.
How to Contact ADP for More Information

If you have any questions about the COBRA law, please contact ADP Benefit Services, 1-888-825-5247, and select option 2, then *, then 1. If you’re outside the U.S. and can’t access the toll-free number, call 610-669-8595 and select option 2, then *, then 1. Or, write to ADP Benefit Services at P.O. Box 2638, Alpharetta, GA 30023-2638.
How to File a Claim for Eligibility

This section describes how to dispute decisions regarding your eligibility to participate in Chevron’s health plans or for credit for health and welfare eligibility service.
If you have a question regarding your eligibility to participate in the Omnibus Health Care Plan or if you believe you are entitled to credit for health and welfare eligibility service, contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.). If you are not satisfied with the outcome, you can file a claim by following the procedures described below.

If you have been denied participation or if you believe you are entitled to credit for health and welfare eligibility service in the Omnibus Health Care Plan, you can file a written claim with the plan administrator. Include the grounds on which your claim is based and any documents, records, written comments or other information you feel will support the claim. Address your written correspondence to:

Chevron Corporation
Omnibus Health Care Plan Administrator
Chevron Human Resources Service Center
P.O. Box 199708
Dallas, TX 75219-9708

If you file a claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan, the plan administrator will send you a decision on the claim within 90 days after the claim is received. However, if there are special circumstances that require additional time, the plan administrator will advise you that additional time is needed and then will send you a decision within 180 days after the claim is received.

If the claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan is denied (in whole or in part), the plan administrator will send you a written explanation that includes:

- Specific reasons for the denial, as well as the specific Omnibus Health Care Plan provisions or Chevron policy on which the denial is based.

- A description of any additional information that could help you complete the claim, and reasons why the information is needed.

- Information about how you can appeal the denial of the claim.

- A statement explaining your right to file a civil lawsuit under section 502(a) of ERISA if your appeal is denied.
Appeals Procedures for Denied Claims Regarding Eligibility to Participate or Credit for Health and Welfare Eligibility Service in the Omnibus Health Care Plan

If your claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan is denied, in whole or in part, and you want to appeal the denial, you must file an appeal within 90 days after you receive written notice of the denial of your claim.

The appeal must be in writing, must describe all of the grounds on which it is based and should include any documents, records, written comments or other information you feel will support the appeal. Before submitting the appeal, you can review and receive, at no charge, copies of Omnibus Health Care Plan documents, records and other information relevant to your claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan.

The Review Panel will provide you with a written response to the appeal and will either reverse the earlier decision and permit participation, or provide credit for health and welfare eligibility service in the Omnibus Health Care Plan, or it will deny the appeal. If the appeal is denied, the written response will contain:

- The specific reasons for the denial and the specific Omnibus Health Care Plan provisions or Chevron policy on which the denial is based.
- Information explaining your right to review and receive, at no charge, copies of Omnibus Health Care Plan documents, records and other information relevant to your claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan.
- A statement explaining your right to file a civil lawsuit under section 502(a) of ERISA.

The Review Panel doesn’t have the authority to change Omnibus Health Care Plan provisions or Chevron policy or to grant exceptions to the Omnibus Health Care Plan rules or Chevron policy.

For appeals regarding participation or credit for health and welfare eligibility service in the Omnibus Health Care Plan, address your written correspondence to:

Review Panel
Omnibus Health Care Plan
P.O. Box 6075
San Ramon, CA 94583-0775

The Review Panel may require you to submit (at your expense) additional information, documents or other material that it believes is necessary for the review.

You will be notified of the final determination of the appeal within 60 days after the date it’s received, unless there are special circumstances that require additional time. You will be advised if more time is needed, and you'll then receive the final determination within 120 days after the appeal is received. If you do not receive a written decision within 60 or 120 days (whichever applies), you can take legal action.
Glossary

Here are some important terms related to the plan(s) discussed in this book.
After-Tax Contributions
After-tax contributions are withheld from your paycheck after federal and state income taxes are withheld.

Allowable Charge
To be considered allowable, an out-of-network charge in the U.S. must be within a range of charges billed by doctors or other providers for the same service or supply. Allowable charges may vary from one geographic area to another. The plan’s claims administrator determines if a charge is allowable. Allowable charges are determined by the claims administrators (other than charges for vision care covered under the plan’s vision program or outpatient prescription drugs covered under the plan’s Prescription Drug Program.

The discounted rates charged by providers in the PPO network aren’t subject to the allowable charge provisions of the plan.

When reviewing charges to determine if they’re covered under the plan, the plan’s claims administrator doesn’t attempt to set the amount that doctors and other providers charge for needed services, nor does the claims administrator restrict your right to go to any doctor you choose.

Before-Tax Contributions
Before-tax contributions are withheld from your pay first, before taxes are calculated and deducted. So you pay less in taxes. Before-tax contributions aren’t subject to federal income taxes, and they aren’t subject to state income taxes except in New Jersey and for some certain benefits, Pennsylvania. Also (unlike before-tax contributions to 401(k) savings plans), before-tax contributions to health plans, the Health Care Spending Account (HCSA) and the Dependent Day Care Spending Account (DCSA) aren’t subject to Social Security taxes.

Before-Tax Contribution Plan
This is a plan that permits you to pay your portion of the monthly costs of any medical, dental, and vision plan coverage with before-tax contributions. If you choose before-tax deductions, you are automatically enrolled in the Before-Tax Contribution Plan. With this plan you are limited in your ability to make enrollment changes in your health plans during the year. Also, if you make contributions on a before-tax basis for medical coverage, you are required to make contributions on a before-tax basis for dental and vision coverage and vice versa.

Brand-Name Drug
Prescription Drug Program (Drugs Obtained Inside the U.S.)
A prescription drug that is all of the following:

- Manufactured and marketed under a trademark or a name given by a specific drug manufacturer.
- Typically protected under patent rights.
- Commonly acknowledged by pharmacies, drug companies and drug manufacturers as a brand-name drug.
Cigna
Cigna insures the health care benefits provided by the Global Choice Plan, which includes inpatient prescription drugs and outpatient prescription drugs obtained outside the U.S. Cigna or its delegate reviews, approves (or denies) and processes all claims (other than claims for outpatient prescription drugs purchased in the U.S. and vision care). In addition, their staff informs plan members which charges are covered and which aren’t under the plan. If you have a question about a claim or if you need to speak with a customer service representative, call Cigna at Toll free: 1-800-828-5822 or Direct (collect calls accepted): 001-302-797-3871. For a list of network providers in the U.S., you can log on to the website at www.cignaenvoy.com.

CignaLinks
CignaLinks is a systematic integration of the global health care program with local administrators (and/or insurers). CignaLinks is currently available in Africa (South Africa, Tanzania, Kenya, Morocco, Egypt, and Nigeria), Australia, Brazil, China, Hong Kong, Indonesia, Macau, Malaysia, the Middle East (Saudi Arabia, United Arab Emirates, Kuwait, Bahrain, Oman, and Qatar), Singapore, Spain, Taiwan, and the United Kingdom. CignaLinks arrangements require a separate ID card, which employees who work or live in these countries will receive upon enrollment.

Casual Employee
An employee who’s hired for a job that’s expected to last no more than four months and who isn’t designated by Chevron as a seasonal employee.

Coinsurance
A way you share costs of services with the plan. You and the plan split the costs by each paying a specified percentage of covered charges.

Common-Law Employee
A worker who meets the requirements for employment status with Chevron under applicable laws.

Company
Chevron Corporation and those of its subsidiaries that it has designated to participate in the Omnibus Health Care Plan and that have accepted such designation by appropriate corporate action. Such designation may include a limitation as to the classes or groups of employees of such subsidiary that may participate in the Omnibus Health Care Plan.

Copayment
A flat-rate charge you pay for office visits or services at the time services are delivered.

Corporation
Refers to Chevron Corporation.

Covered Charges
Applies only to medical coverage. Refer to Section 12 of the Cigna Certificate of Coverage.
Doctor
The term *doctor* means a doctor or surgeon (M.D.), a psychiatrist (M.D.), an osteopath (D.O.), a podiatrist (D.P.M.), a dentist (D.M.D. or D.D.S.), a chiropractor (D.C.) and an ophthalmologist (O.D.).

For care to be covered under the plans, the doctor must be licensed by the proper authorities of the state in which he or she practices, and practice and treatment must be within the scope of the doctor’s license.

Former Atlas Employee
A person who otherwise qualifies as an eligible employee and who was employed by Atlas immediately prior to its merger with Chevron Corporation (or was employed by Chevron Northeast Upstream Corporation after the merger and on or before October 1, 2011) and who has not been terminated and rehired by Chevron or its affiliates.

Former Caltex Employee
A person who otherwise qualifies as an eligible employee and who was employed by Caltex immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron or its affiliates.

Former Chevron Employee
A person who otherwise qualifies as an eligible employee and who was employed by Chevron immediately prior to its merger with Texaco Inc. and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

Former Texaco Employee
A person who otherwise qualifies as an eligible employee and who was employed by Texaco Inc. immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

Former Unocal Employee
A person who otherwise qualifies as an eligible employee and who was employed by Unocal immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron since the merger with Unocal.

Generic Drug
Prescription Drug Program (Drugs Obtained Inside the U.S.)
A chemical copy of a brand-name prescription drug. Generic medications contain the same active ingredients and must be equivalent in strength and dosage to their brand-name counterparts. They are subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength and purity as their brand-name counterparts. Generally, generic drugs cost less than brand-name drugs.

Some generics look different from the brand-name version of the drug because they contain different inactive ingredients. Inactive ingredients are, for example, additives that are used to keep a tablet from crumbling, to add bulk to a tablet, or to change a tablet’s color or shape. Generic drugs typically cost 30 percent to 60 percent less than their brand-name counterparts because manufacturers of generic drugs don’t have to pay for research and development or marketing and advertising.
Health and Welfare Eligibility Service

Your health and welfare eligibility service is used to determine your eligibility for vacation, service awards, Short-Term and Long-Term Disability plans and retiree health care benefits. The following applies to an individual who is an employee on or after January 1, 2012. Different rules apply to an individual who terminated employment prior to January 1, 2012.

Health and welfare eligibility service is generally the period of time you’re employed by Chevron or by any other member of the Chevron affiliated group, and may include periods when you’re not an eligible employee for U.S. pay and benefits.

Health and welfare eligibility service includes all the time you are on an approved Disability Leave for which you are receiving benefits under the Chevron Long-Term Disability Plan. Under special rules, it may also include the time you are on certain other approved leaves of absence. Special rules apply if you do not timely return to active work with a participating company or if you terminate your employment while on an approved leave of absence. Health and welfare eligibility service may also include the time you have been providing services as a “leased employee” on or after July 1, 2002 to a member of the Chevron affiliated group (at the time the services are performed) and you become an employee after providing service as a leased employee, as determined by Chevron in its sole discretion. If you believe one of these special rules apply to you, contact the HR Service Center for further information.

If you leave Chevron after July 1, 2002, and are rehired within 365 days, your service will include the time you were away. If you’re gone longer than 365 days and you haven’t had a permanent service break as a result of your absence, your service before you left will be added to your service after you’re rehired.

If you left Chevron and were rehired, your service before you left will be added to your service after you’re rehired unless you incurred a Permanent Service Break. If you have service with an acquired company prior to the date of the acquisition of that company by Chevron, special rules may apply — contact the HRSC for more information.

Note on grandfathering rules: The definition of health and welfare service has changed over time, and sometimes it has changed to include additional service that was not previously included. This will not change whether you are subject to a grandfather rule in effect prior to the change. This is because whether an employee meets the conditions to have a grandfather rule apply is determined under the rules in place as of the time the grandfather rule was effective.

HIPAA

The Health Insurance Portability and Accountability Act of 1996, as amended from time to time.
Hospital
A hospital must meet one of the following requirements:

- A legally constituted and operated institution having, on its premises, organized facilities (including diagnostic and major surgical facilities) for the care and treatment of sick and injured people. Care must be supervised by a staff of legally qualified doctors, and there must be a registered nurse (R.N.) on duty at all times.

- A free-standing rehabilitative facility that meets all of the following criteria:
  
  — Has a provider agreement, as required by Medicare.
  — Serves an inpatient population, with at least 75 percent of patients needing intensive rehabilitative services for the treatment of a stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of the femur, brain injury, polyarthritis, neurological disorders and burns.
  — Has a preadmission screening procedure to determine whether the patient would benefit from an intensive inpatient hospital program.
  — Ensures that patients receive close medical supervision and furnishes rehabilitation nursing, physical therapy and occupational therapy by qualified personnel.
  — Has a director of rehabilitation who is a doctor.
  — Establishes a plan of treatment for every patient that is reviewed as needed by a doctor who consults with other qualified personnel.
  — Uses a coordinated team approach to rehabilitate each patient.

The term *hospital* doesn’t include any of the following facilities:

- Any institution used primarily as a rest or nursing facility.
- Any facility solely for use by the aged or the chronically ill or alcoholics.
- Any facility providing primarily educational or custodial care.

Incapacitated Child
An incapacitated child is a dependent child who is:

- Incapable of self-sustaining employment by reason of mental retardation or a mental or physical disability (proof of which must be medically certified by a physician).

- Dependent on you, you and your spouse/domestic partner or your surviving spouse/domestic partner who is covered under the plan, for more than one-half of his or her financial support.

- Your or your spouse/domestic partner’s qualifying child under Section 152 of the Internal Revenue Code. This means that during the calendar year the individual 1) is your child, brother, sister stepbrother, stepsister or a descendent of such person; 2) lives with you for more than one-half the year and 3) does not provide over one-half of his or her own support.
The dependent child must be incapacitated under one of the following conditions:

- Immediately before turning age 26 while being covered under a Chevron health care plan.
- Before turning age 26 if he or she had other health care coverage immediately before you became an eligible employee and is enrolled in a Chevron health care plan within 31 days after you become an eligible employee.
- Before turning age 26 if he or she had other health care coverage immediately before the dependent child was enrolled in a Chevron health care plan.

When the child reaches age 26, and periodically thereafter, Chevron Corporation will require you to provide documentation stating that the child continues to be incapacitated. For chronic disabilities, as determined by UnitedHealthcare, you must provide documentation every two years. If the disability is not chronic, UnitedHealthcare will determine how frequently you will need to provide such documentation. For details, contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.).

**Leased Employee**
Someone who provides services to Chevron in a capacity other than that of a common-law employee and who meets the requirements of section 414(n) of the Internal Revenue Code. This law requires Chevron to treat leased employees as if they’re common-law employees for some purposes, but doesn’t require that they be eligible for benefits.

**Maintenance Medication**
**Prescription Drug Program (Drugs Obtained Inside the U.S.)**
Medication taken over an extended period of time (90 days or more) for the treatment of a chronic condition, such as diabetes, arthritis, ulcers, high blood pressure or heart conditions.

**Managed Prior Authorization**
The Express Scripts program that requires certain drugs to be approved by Express Scripts before the drug is dispensed in order for the drug to quality as a covered charge.

**Medical Channel Management**
The Express Scripts program aimed at identifying opportunities for shifting drug utilization from the medical channel to the pharmacy channel with respect to specialty drugs.

**Multi-Source Drug**
A medication that is available from multiple manufacturers and can include Brand-Name and Generic drugs depending on patent status.

**Network Pharmacy**
**Prescription Drug Program (Drugs Obtained Inside the U.S.)**
Express Scripts, the administrator of the Prescription Drug Program’s retail pharmacy program, has negotiated a discount agreement with more than 64,000 pharmacies across the U.S. These pharmacies make up a network that includes pharmacy chains, pharmacies at discount stores, pharmacies at local and national grocery chains and many independent pharmacies. For participating pharmacies near you, visit [www.Express-Scripts.com](http://www.Express-Scripts.com) or call Express Scripts Member Services at 1-800-987-8368.
Network Price (Prescription Drug Program)

*Drugs Obtained Inside the U.S.*

A discounted price charged for a prescription when a network pharmacy is used.

Nonpreferred Brand-Name Drugs (Prescription Drug Program)

*Drugs Obtained Inside the U.S.*

Drugs that are covered by the Prescription Drug Program, which receive a lower level of reimbursement compared with preferred brand-name drugs. These drugs are not on Express Scripts’ list of preferred brand-name drugs.

Nurse

A registered nurse (R.N.), licensed vocational nurse (L.V.N.) or licensed practical nurse (L.P.N.).

Open Enrollment

Typically, open enrollment is held annually during a two-week period each fall. During open enrollment, you can make changes to your benefit elections and such changes will take effect the following January 1.

Out-of-Pocket Maximum

After you pay your deductible, the plan pays a percentage of covered charges for the care you need and you pay any costs above the amount paid by the plan.

After your out-of-pocket costs reach the specified amount for the coverage tier, the plan pays 100 percent of all covered charges until the end of the calendar year.

Outpatient Care

Care provided without an overnight stay in a hospital.

Outpatient Prescription Drugs

*Prescription Drug Program (Drugs Obtained Inside the U.S.)*

Drugs that are dispensed by a retail or home delivery pharmacy (excluding drugs dispensed at hospitals, doctors’ offices or skilled nursing facilities).

Payroll

The system used by Chevron to withhold employment taxes and pay its common-law employees. The term doesn’t include any system to pay workers whom Chevron doesn’t consider to be common-law employees and for whom employment taxes aren’t withheld, such as workers Chevron regards as independent contractors or common-law employees of independent contractors.

Permanent Service Break (for health and welfare eligibility service)

You will not have a permanent service break if you leave Chevron with more than five years of health and welfare eligibility service. You will, however, have a permanent service break if you leave Chevron before you have five years of health and welfare eligibility service and you’re not rehired within five years. If you left Chevron before July 1, 2002 and are not an eligible employee at any time on or after January 1, 2012, applicable rules at the time of your termination will apply to whether you had a permanent service break.
Preferred Brand-Name Drugs
Prescription Drug Program (Drugs Obtained Inside the U.S.)
Drugs that are covered by the Prescription Drug Program and receive a higher level of reimbursement compared with nonpreferred drugs. The list of preferred brand-name drugs (sometimes called a formulary list) includes commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings. Preferred brand-name drugs receive a higher level of reimbursement compared with nonpreferred brand-name drugs. For updated formulary information, visit www.Express-Scripts.com or call Express Scripts Member Services at 1-800-987-8368.

Primary Payer
The plan that pays benefits first.

Professional Intern
An individual who works either a full-time or part-time work schedule and whose work periods with Chevron alternate with school periods.

Provider
A hospital, medical or health care facility, doctor, dentist or other health professional licensed where required, performing within the scope of that license.

- A participating provider or network provider has agreed to charge discounted rates for services provided to plan members. To encourage you to use these providers, the plan often pays a higher benefit rate for network services. Also, you generally don’t have to file a claim form when you go to a network provider. You can obtain a list of network providers in your area by contacting your claims administrator.

- A nonparticipating or out-of-network provider does not have an agreement with the claims administrator pertaining to the payment of covered services for a member.

Regular Work Schedule
A continually recurring pattern of scheduled work that’s established and changed by Chevron as necessary to meet operating needs.

Rotational Expatriate Assignment
Chevron has operations in locations where no adequate resources are available to provide the necessary infrastructure and support for expatriate families to reside. Elsewhere, particular circumstances (for example, climate, remote location, and security) render the location unsuited for family living. In those circumstances, expatriate assignments are administered under the Rotational Expatriate Assignment policy. Under the terms of the policy, the family stays in the home location, and the employee commutes to the host-country work location, works a designated number of days in the host country during which room and board is provided, followed by an equal number of days off.

Seasonal Employee
An individual who’s hired to work a regular work schedule for a portion of each year on a repetitive basis in a job designated to cover a seasonal operating need.
Secondary Payer
The plan that pays benefits second.

Single-Source Brand-Name Drugs
A Brand-Name Drug that doesn’t have a generic equivalent and is only available from one manufacturer or source, typically the original company.

Specialty Drug
Prescription Drug Program (Drugs Obtained Inside the U.S.)
A prescription drug that Express Scripts has designated as a Specialty Drug. In general, Specialty Drugs are high-cost drugs that may be used to treat complex or rare medical conditions. Specialty Drugs are generally biotechnological in nature and may have special shipping, storage or handling requirements. Specialty Drugs often require injection or other non-oral methods of administration.

Some of the disease categories for which certain prescription drugs are currently designated as Specialty Drugs by Express Scripts’s include cancer, cystic fibrosis, Gaucher disease, growth hormone deficiency, hemophilia, immune deficiency, Hepatitis C, infertility, multiple sclerosis, rheumatoid arthritis, and RSV prophylaxis. Express Scripts may add or delete drugs from the Specialty category as new treatments become available.

For information on whether a particular drug is a Specialty Drug, or whether it is subject to the home delivery requirement for maintenance Specialty Drug refills, contact Express Scripts at 1-800-987-8368.

Spouse
A person to whom you are legally married under the law of a state or other jurisdiction where the marriage took place.

Urgent Care Claim
Any claim for medical care or treatment with respect to which the application of the time periods for making nonurgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or which, in the opinion of your doctor, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

VSP (Vision Service Plan) Vision Care
VSP is the insurer for the vision benefits you receive through the Medical PPO and also the Vision Plus program. VSP manages the plan’s preferred provider organization and processes claims filed by you or your provider. VSP can be reached by telephone at 1-800-877-7195 Monday through Friday from 5 a.m. to 7 p.m. Pacific time, on Saturday from 7 a.m. to 8 p.m. Pacific time and on Sunday from 7 a.m. to 7pm Pacific time. If you're outside the U.S. and unable to access the toll-free number you may contact VSP by telephone at (916) 851-5000 (press “0” for operator assistance) Monday through Friday from 7 a.m. to 5 p.m. Pacific time. Or you can access the VSP’s website at www.vsp.com/go/chevron.
Company Contributions to Medical Coverage
Supplement to the Summary Plan Description (SPD)
Effective January 1, 2014

This supplement generally describes the Chevron Corporation Policy regarding its contribution to the cost of medical coverages that are eligible for a Chevron company contribution. This is not a plan text, a summary plan description or a summary of material modification because the amount of the company contribution and how it is determined is not itself part of a medical plan. Nevertheless, if it should be determined to be part of a medical plan, the Supplement, as modified herein, shall constitute the applicable plan provision and summary plan description. There are no vested rights with respect to Chevron medical plans or any company contributions toward the cost of such medical 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 was previously subject to a grandfathering provision. Some benefit plans and policies described in the Supplement may be subject to collective bargaining and, therefore, may not apply to union-represented employees.
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Benefits Connection Website
The Benefits Connection website provides information about the company contribution to medical coverage.

- **hr2.chevron.com.** Click the Benefits Connection link near the top of the page to get started.
- Go to the Health and Welfare tab on the top navigation for the current company contribution to your medical coverage.
- Go to the Retirement Plan tab on the top navigation for:
  - The date you may be eligible for retiree medical coverage.
  - To access a calculator that will help you project the future percentage of the company contribution to retiree medical coverage.

HR Service Center

- 1-888-825-5247 (Inside the U.S.)
- 610-669-8595 (Outside the U.S.)
- 6 a.m. to 5 p.m., Pacific time (8 a.m. to 7 p.m., Central time)
- Monday through Friday, except on holidays.

Read Summary Plan Descriptions Online
You can find summary plan descriptions, general benefit summaries and information about the medical plans Chevron offers to active employees and retirees on the U.S. Benefits website.

- hr2.chevron.com
Company Contributions to Employee Medical Coverage

Chevron Corporation determines the total cost of the various medical plans it offers. In general, Chevron Corporation has an “80/20” cost-sharing approach with respect to such total cost. This means that the company pays approximately 80 percent of that cost, and you pay the remaining 20 percent. With this approach, Chevron typically pays 80 percent of the premium for your health care plan or a set maximum company contribution, whichever is less. The maximum company contribution is based on 80 percent of the total premium of the Medical PPO Option 2. If your plan costs less, Chevron will pay 80 percent of the cost of your plan. If your plan costs more, Chevron will pay up to the maximum contribution.

Example
Here’s an example based on family coverage:

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>2014 Monthly Cost for Family Coverage</th>
<th>Company Contribution Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Premium</td>
<td>Company Contribution</td>
</tr>
<tr>
<td>Medical PPO Option 2</td>
<td>$1,585</td>
<td>$1,269</td>
</tr>
<tr>
<td>Medical PPO Option 1</td>
<td>$1,709</td>
<td>$1,269</td>
</tr>
<tr>
<td>Global Choice Plan</td>
<td>$1,241</td>
<td>$993</td>
</tr>
</tbody>
</table>

Medical PPO Option 2 has a total premium of $1,585. Eighty percent of that total premium is the maximum company contribution for family coverage ($1,269).

As you can see, the Medical PPO Option 1 premium is more than Medical PPO Option 2. Therefore, the company contribution equals the set maximum of $1,269.

Based on 80 percent of the total premium for Medical PPO Option 2, here are the maximum monthly contributions for all coverage levels:

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>2014 Maximum Monthly Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>You Only</td>
<td>$470</td>
</tr>
<tr>
<td>You and One Adult</td>
<td>$940</td>
</tr>
<tr>
<td>You and Child(ren)</td>
<td>$799</td>
</tr>
<tr>
<td>You and Family</td>
<td>$1,269</td>
</tr>
</tbody>
</table>
Company Contributions to Retiree Medical Coverage

If you’re an eligible retiree, the company currently continues to share the cost of your medical coverage. In general, to be eligible for retiree medical coverage, you must meet both of the following requirements:

- You are at least age 50 with 10 years or more of health and welfare eligibility service.
- At least five years of your total health and welfare eligibility service occurred since your last rehire date.

If you are a retiree not eligible for Medicare, your starting company contribution to retiree medical coverage will be based on the maximum active employee company contribution amount in the calendar year you retire. This amount will be prorated based on the applicable percentage corresponding to your points, as described below. Please note that the cost of retiree medical coverage is greater than the maximum company contribution, so even if you have enough points to receive 100 percent of the company contribution, you will still have to pay for coverage.

The company contribution amount toward retiree medical coverage is different if you are Medicare-eligible when you retire or if you become Medicare-eligible as a retiree. All Medicare-eligible retirees receive the same company contribution amount, regardless of year of retirement. Your actual company contribution amount is prorated based on the applicable percentage corresponding to your points at retirement, as described below.

The base company contribution is determined by the calendar year you separate from the company. If you are subsequently rehired, the company contribution determination will continue to be based on your first separation date. Chevron limits future increases to the applicable company contribution to no more than 4 percent each year, applied to the starting or existing company contribution amount.

Company Contribution Amount and Proration of Company Contribution Amount

As indicated above, your applicable starting company contribution amount may be prorated based upon your “points” at retirement. Points represent the sum of your age plus years of health and welfare eligibility service when you leave the company. Each point level corresponds to a percentage, which represents the percentage of the company contribution for which you are eligible. In general, the longer you work, the more points you can accumulate, resulting in a higher percentage and therefore a higher company contribution amount toward retiree medical coverage.

In general, if you retired on or after July 1, 2002, one of the following point scales is used to determine the amount of company contribution you receive:

- The 90-point scale applies to retirees eligible for retiree medical who terminate or retire on or after January 1, 2005, unless a grandfather rule applies to you.
- The 80-point scale applies to retirees eligible for retiree medical who retired between July 1, 2002, and December 31, 2004, and to employees who were age 50 or over with at least 10 years of service on December 31, 2004 (as determined under the applicable rules in effect on December 31, 2004), and who retire after that date, unless a grandfather rule applies to you.
The following chart indicates the company contribution under the 80-point scale and the 90-point scale:

<table>
<thead>
<tr>
<th>Age Plus Years of Health and Welfare Service Points</th>
<th>Company Contribution Under the:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80-Point Scale</td>
</tr>
<tr>
<td>60</td>
<td>50%</td>
</tr>
<tr>
<td>61</td>
<td>52.5%</td>
</tr>
<tr>
<td>62</td>
<td>55%</td>
</tr>
<tr>
<td>63</td>
<td>57.5%</td>
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<td>64</td>
<td>60%</td>
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<td>65</td>
<td>62.5%</td>
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<td>67</td>
<td>67.5%</td>
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<td>68</td>
<td>70%</td>
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<tr>
<td>69</td>
<td>72.5%</td>
</tr>
<tr>
<td>70</td>
<td>75%</td>
</tr>
<tr>
<td>71</td>
<td>77.5%</td>
</tr>
<tr>
<td>72</td>
<td>80%</td>
</tr>
<tr>
<td>73</td>
<td>82.5%</td>
</tr>
<tr>
<td>74</td>
<td>85%</td>
</tr>
<tr>
<td>75</td>
<td>87.5%</td>
</tr>
<tr>
<td>76</td>
<td>90%</td>
</tr>
<tr>
<td>77</td>
<td>92.5%</td>
</tr>
<tr>
<td>78</td>
<td>95%</td>
</tr>
<tr>
<td>79</td>
<td>97.5%</td>
</tr>
<tr>
<td>80</td>
<td>100%</td>
</tr>
<tr>
<td>81</td>
<td></td>
</tr>
<tr>
<td>82</td>
<td></td>
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<tr>
<td>83</td>
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<td>84</td>
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<td>88</td>
<td></td>
</tr>
<tr>
<td>89</td>
<td></td>
</tr>
<tr>
<td>90</td>
<td></td>
</tr>
</tbody>
</table>
Grandfather Rules
There are some exceptions to the company contribution amount you may receive. Some retirees are eligible for retiree health care coverage at 100 percent of the maximum company contribution under the rules of former Chevron, former Texaco or former Unocal plans. In these cases, retirees have been protected, or grandfathered, under old or alternate rules. These grandfather rules are described below:

- A former Chevron employee is a person who otherwise qualifies as an eligible employee and who was employed by Chevron immediately prior to its merger with Texaco Inc. and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

- A former Texaco employee is a person who otherwise qualifies as an eligible employee and who was employed by Texaco Inc. immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

- A former Unocal employee is a person who otherwise qualifies as an eligible employee, who was employed by Unocal immediately prior to its merger with Chevron Corporation, and who has not been terminated and rehired by Chevron since the merger with Unocal.

- Whether an employee meets the conditions to have a grandfather rule (including the 80-point scale) apply is determined under the rules in place as of the time the grandfather rule became effective. For example, a change to the health and welfare eligibility service, effective January 1, 2012, does not affect the amount of service the employee had on December 31, 2004 for purposes of whether the 80-point scale applies. (However, if the 80-point scale applies to an employee without regard to the additional service, the additional service would count toward the employee’s points on the 80-point scale).

If you're a former Chevron, or former Caltex or former Texaco employee and meet one of the following grandfathering requirements, you receive 100 percent of the company’s contribution toward your medical coverage when you retire, subject to the 4 percent limit on future increases to the company contribution:

- You’re a former Chevron or former Caltex employee employed by the company on June 30, 2002, and you meet all of the following criteria:
  - You must have had at least 20 years of continuous service or 65 points (age plus years of continuous service) on June 30, 2002, (as determined under the applicable rules in effect on June 30, 2002).
  - You have at least 25 years of health and welfare eligibility service or at least 75 points (age plus years of health and welfare eligibility service) when you retire.
  - You have not been rehired since July 1, 2002.

- You’re a former Texaco employee employed by the company on June 30, 2002, and on October 1, 1999, you were a Texaco employee who was age 45 or older and you retire at age 55 or older with at least 10 years of health and welfare eligibility service.
If you’re a former Unocal employee employed by the company on June 30, 2006, you may be eligible for a company contribution percentage based on the grandfathered Unocal transition scale. If you retire on or after July 1, 2006, at age 55 or older with 10 or more years of health and welfare eligibility service, and you meet the age and service requirements by December 31, 2007, (as determined under the applicable rules in effect on December 31, 2007), you will be eligible for the greater (that is, the greater company contribution percentage) of the Chevron 90-point scale or the grandfathered Unocal transition scale shown below:

### Grandfathered Unocal Transition Scale

<table>
<thead>
<tr>
<th>Years of Service After Age 35</th>
<th>Company Contribution Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>50.0%</td>
</tr>
<tr>
<td>11</td>
<td>55.0%</td>
</tr>
<tr>
<td>12</td>
<td>60.0%</td>
</tr>
<tr>
<td>13</td>
<td>65.0%</td>
</tr>
<tr>
<td>14</td>
<td>70.0%</td>
</tr>
<tr>
<td>15</td>
<td>75.0%</td>
</tr>
<tr>
<td>16</td>
<td>80.0%</td>
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<td>17</td>
<td>85.0%</td>
</tr>
<tr>
<td>18</td>
<td>90.0%</td>
</tr>
<tr>
<td>19</td>
<td>95.0%</td>
</tr>
<tr>
<td>20</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

### Rehired Retirees Who Subsequently Retire a Second Time

If you retire from Chevron having met eligibility requirements for retiree medical coverage under any applicable eligibility rule at the time you retire, and you subsequently are rehired and then retire again, you are eligible for the better of the corresponding company contribution to retiree medical coverage based on the date you first retired (as in effect at the time of your second retirement) and any subsequent eligibility for retiree medical for which you qualify, taking into account your second period of employment.
Examples: How Points and Company Contributions Amounts Are Determined with Respect to Retiree Medical Coverage

Here are some examples to help you understand how points and company contribution amounts are determined. These examples assume that the individuals qualify for retiree medical coverage. They are estimates in which the age, service and points are rounded for purposes of the illustration only. Actual age plus years of service point calculations performed by the HR Service Center upon an employee’s retirement extend to four decimal points, and service is currently counted until the end of the month in which the employee terminates Chevron employment.

Chris, a Chevron employee retiring under the new 90-point scale
Chris is 36 years old with seven years of service.

Chris’ points
Chris has 43 age plus years of service points (36 years old plus seven years of service). Chris is not eligible for retiree medical coverage because he is not 50 years old with 10 years of service. When Chris turns 50, he will have 71 age plus years of service points, making him eligible for 61 percent of the maximum applicable company contribution for retiree medical coverage. Because Chris is not eligible for any grandfathering, he will need 90 points to qualify for 100 percent of the applicable company contribution for retiree medical coverage.

Chris’ eligibility for the 100 percent company contribution
When Chris has 90 age plus years of service points he will be eligible for 100 percent of the applicable company contribution for retiree medical coverage.

Pat, a Chevron employee grandfathered under the 80-point scale
Pat is grandfathered under the grandfathering provision — age 50 or older with 10 years of service on December 31, 2004. Pat is 56 years old with 16 years of service.

Pat’s points
Pat has 72 age plus years of service points (56 years old plus 16 years of service), making her eligible for 80 percent of the applicable company contribution for retiree medical coverage.

Pat’s eligibility for the 100 percent company contribution
Pat will be eligible for 100 percent of the applicable company contribution for retiree medical coverage when she earns 80 age plus years of service points.
Robert, a former Chevron employee
Robert is a former Chevron employee, grandfathered under former Chevron rules. Robert is 58 years old with 28 years of service.

Robert’s points
Robert has 86 age plus years of service points. Robert is grandfathered under the former Chevron rule because he had at least 20 years of continuous service or 65 points on June 30, 2002, and when he retires he will have at least 25 years of health and eligibility service or at least 75 points.

Robert’s eligibility for 100 percent of the applicable company contribution
Because he was eligible for the grandfather rule, Robert currently is eligible for 100 percent of the applicable company contribution.

Maria, a former Texaco employee
Maria is a former Texaco employee, grandfathered under the former Texaco rules, who was age 45 or older on October 1, 1999. Maria is 60 years old with 16 years of service.

Maria’s points
Maria has 76 points. However, Maria should not refer to the 80-point scale to determine her percentage of company contribution since she already meets the former Texaco grandfather rules as noted below.

Maria’s eligibility for 100 percent of the applicable company contribution
Because she was age 45 or older as of October 1, 1999, and will be retiring at age 55 or older with 10 years of health and welfare eligibility service, Maria is currently eligible to retire with 100 percent of the applicable company contribution.
**Terry, a former Unocal employee**

Terry is a former Unocal employee who wants to retire and who is 59 years old with 26 years of service. He will have 85 points (59 + 26) under the Chevron 90-point scale — equivalent to a company contribution percentage of 85 percent of the starting maximum company contribution amount for this year. However, Terry meets the requirements of the grandfathered Unocal transition scale (the Unocal transition scale gives him 100 percent of the applicable company contribution).

**Terry’s eligibility for 100 percent of the applicable company contribution**

Terry meets the age and service requirement for eligibility under the grandfathered Unocal transition scale because he had 20-plus years of service after age 35 on December 31, 2007. According to the Unocal transition scale, this service is equivalent to 100 percent of the applicable company contribution. The greater amount (100 percent) will be applied against the total cost of retiree coverage.

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**Mike, a former Unocal employee**

Mike is a former Unocal employee who wants to retire. As of December 31, 2007, he was age 54 with 20 years of service. He does not meet the eligibility requirements for the grandfathered Unocal transition scale because he did not satisfy the age and service requirements by December 31, 2007. Therefore, when he retires, he will be eligible for the Chevron 90-point scale.

**Mike’s eligibility for 100 percent of the applicable company contribution**

Mike will be eligible for 100 percent of the applicable company contribution for retiree medical coverage when he earns 90 age plus years of service points.
About Health and Welfare Eligibility Service

Definition of Health and Welfare Eligibility Service

Your health and welfare eligibility service is used to determine your eligibility for vacation, service awards, Short-Term and Long-Term Disability plans and retiree health care benefits. The following applies to an individual who is an employee on or after January 1, 2012. Different rules apply to an individual who terminated employment prior to January 1, 2012.

Health and welfare eligibility service is generally the period of time you’re employed by Chevron or by any other member of the Chevron affiliated group, and may include periods when you’re not an eligible employee for U.S. pay and benefits.

Health and welfare eligibility service includes all the time you are on an approved Disability Leave for which you are receiving benefits under the Chevron Long-Term Disability Plan. Under special rules, it may also include the time you are on certain other approved leaves of absence. Special rules apply if you do not timely return to active work with a participating company or if you terminate your employment while on an approved leave of absence. Health and welfare eligibility service may also include the time you have been providing services as a “leased employee” on or after July 1, 2002 to a member of the Chevron affiliated group (at the time the services are performed) and you become an employee after providing service as a leased employee, as determined by Chevron Corporation in its sole discretion. If you believe one of these special rules apply to you, contact the HR Service Center for further information.

If you leave Chevron after July 1, 2002, and are rehired within 365 days, your service will include the time you were away. If you’re gone longer than 365 days and you haven’t had a permanent service break as a result of your absence, your service before you left will be added to your service after you’re rehired.

If you left Chevron and were rehired, your service before you left will be added to your service after you’re rehired unless you incurred a Permanent Service Break. If you have service with an acquired company prior to the date of the acquisition of that company by Chevron, special rules may apply — contact the HR Service Center for more information.

Note on grandfathering rules: The definition of health and welfare eligibility service has changed over time, and sometimes it has changed to include additional service that was not previously included. This will not change whether you are subject to a grandfather rule in effect prior to the change. This is because whether an employee meets the conditions to have a grandfather rule apply is determined under the rules in place as of the time the grandfather rule was effective.

Definition of a Permanent Service Break

You will not have a permanent service break if you leave Chevron with more than five years of health and welfare eligibility service. You will, however, have a permanent service break if you leave Chevron before you have five years of health and welfare eligibility service and you’re not rehired within five years. If you left employment with Chevron before January 1, 2012, the applicable rules at the time of your termination will apply to whether you had a permanent service break.
Glossary

**Former Atlas Employee**
A person who otherwise qualifies as an eligible employee and who was employed by Atlas immediately prior to its merger with Chevron Corporation (or was employed by Chevron Northeast Upstream Corporation after the merger and on or before October 1, 2011) and who has not been terminated and rehired by Chevron or its affiliates.

**Former Caltex Employee**
A person who otherwise qualifies as an eligible employee and who was employed by Caltex immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron or its affiliates.

**Former Chevron Employee**
A person who otherwise qualifies as an eligible employee and who was employed by Chevron immediately prior to its merger with Texaco Inc. and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

**Former Texaco Employee**
A person who otherwise qualifies as an eligible employee and who was employed by Texaco Inc. immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

**Former Unocal Employee**
A person who otherwise qualifies as an eligible employee and who was employed by Unocal immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron since the merger with Unocal.