health care spending account

flexible spending account plan summary plan description

effective january 1, 2020

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This document describes the Health Care Spending Account (HCSA) Plan, as of January 1, 2020, that Chevron sponsors for eligible employees on the U.S. payroll of Chevron or a participating company. This information constitutes the summary plan description (SPD) of the Plan as required by the Employee Retirement Income Security Act of 1974 (ERISA). These descriptions don't cover every provision of the plan. Many complex concepts have been simplified or omitted to present more understandable plan descriptions. If these 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 to the extent permitted by law.

Chevron Corporation reserves the right to change or terminate a plan or program 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.

To find general benefit summaries and information about other plans that Chevron offers, visit the U.S. Benefits website at **hr2.chevron.com**.

update to addresses
for benefits correspondence
effective June 1, 2020

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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

carryover, extended claims deadline and annual contribution limit

health care spending account plan

effective january 1, 2022 through december 31, 2022

human energy. yours.™

Update to the summary plan descriptions (SPD)
Changes described in this SMM are effective January 1, 2022, through December 31, 2022.

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

introduction

This document describes the following changes to the Chevron Health Care Spending Account (HCSA) Plan as permitted by the 2021 Consolidated Appropriation Act:

- Temporary carryover opportunity for unused 2021 health care flexible spending account funds into 2022.
- Deadline to submit claims for eligible expenses incurred January 1, 2021, through December 31, 2021, is temporarily extended.

These expanded rules are effective as of January 1, 2022, and remain available to Chevron Health Care Spending Account (HCSA) Plan participants through December 31, 2022, as described in this document.

This document applies to eligible, active U.S.-payroll employees.

who to contact

- Contact **Anthem** directly at **1-844-627-1632** to discuss reimbursement claims, eligible expenses, the HCSA debit card, or other carryover questions.
- HCSA information and claim resources are available on **hr2.chevron.com**. Go to **Health Plans** on the top navigation, then choose **Health Accounts** from the dropdown menu.

As a reminder, if you are enrolled in the High Deductible Health Plan (HDHP) or the High Deductible Health Plan Basic (HDHP Basic), you cannot also participate in the HCSA.

claims deadline extended

As a reminder, due to the current global pandemic, the deadline to submit claims for eligible expenses incurred **January 1, 2021,** through **December 31, 2021,** has been extended. The deadline for 2021 claims is **60 days** after the President announces the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak *or* **June 30, 2022**, whichever occurs *later*. **After the applicable claims deadline, you can no longer submit a claim for expenses incurred in 2021.**

While you have extra time to submit claims if you need it, we *strongly* encourage you to submit as many of these claims as possible prior to the normal claims deadline of June 30, 2022, to assist with processing the carryover of your 2021 HCSA (if any).

2022 maximum annual contribution limit

For your reference, effective **January 1, 2022,** the maximum amount you're allowed to contribute to the Chevron Health Care Spending Account (HCSA) is as follows:

- You can contribute up to **$2,750**. This is the same maximum amount as allowed in 2021.
- If you're eligible for the carryover of your 2021 HCSA (as described in the *Carryover* section), your carryover amount **does not** count toward the 2022 annual maximum; your carryover amount will be **added to** the amount you elect (if any) to contribute to the HCSA for 2022. For example, if you elect to contribute the maximum of $2,750 in 2022 and you're eligible for a 2021 HCSA carryover of $1,000, you will be eligible to spend a total of $3,750 from January 1, 2022, through December 31, 2022, under the 2022 HCSA. See the **Carryover** section in this document for additional details.
- Chevron *does not* contribute to the HCSA.

(continued next page)

temporary carryover opportunity

active employee coverage

Typically, the money in your HCSA can be used only for eligible expenses incurred between January 1 and December 31 in the year you are enrolled. Any remaining balance left in your account after the final claim filing deadline will be forfeited.

Due to the COVID-19 public health emergency, HCSA participants may have more unused HCSA amounts at the end of the plan year than in previous years. To address this issue, Congress and the IRS temporarily adjusted standard flexible spending account rules and requirements. **Chevron has adopted this increased flexibility for January 1, 2022, through December 31, 2022, and Chevron HCSA Plan participants now have access to carryover balances as described in this document.**

who is eligible for the carryover

To be eligible for the special, carryover opportunity, you must satisfy **all** of the following requirements:

- You were a U.S.-payroll employee **enrolled in the HCSA** for all or part of the 2021 plan year.
- You have **at least $25** in **unused funds** in your 2021 HCSA. There is *no* maximum limit to the amount you're permitted to carry over.

You do not have to be enrolled in or contribute to the HCSA in 2022 to receive your carryover, if any. However, if you are enrolled in the Chevron High Deductible Health Plan (HDHP) or the Chevron High Deductible Health Plan Basic (HDHP Basic) in 2022, you still *cannot* also participate in the HCSA in 2022 and therefore **are not eligible** for the carryover.

how the carryover works

Step 1: Submit your outstanding 2021 claims.

While the claims deadline has been extended for eligible expenses incurred January 1, 2021, through December 31, 2021, you're strongly encouraged to submit claims as soon as they happen. Claims for eligible expenses submitted by June 30, 2022, will be paid from your 2021 HCSA account balance.

example

You elected to contribute $1,000 to your 2021 HCSA account.

Prior to adopting the carryover, the money in your 2021 HCSA could be used for eligible expenses incurred January 1, 2021, through December 31, 2021.

Expense	2021 Account balance is now …
$100 on July 8, 2021, using your HCSA debit card.	$900
$50 on September 12, 2021, using your HCSA debit card.	$850
You submit a claim form on June 10, 2022, for a $100 eligible expense incurred on March 10, 2021, that you forgot about.	$750

Legacy Noble employees: As a reminder, the carryover and other plan updates described in this document apply only to the Chevron HCSA; they do not apply to your Noble FSA. In addition, if you enroll in the Chevron 2021 HCSA, remember that eligible expenses incurred **October 1, 2021,** through **December 31, 2021,** apply to your Chevron 2021 HCSA. Outstanding claims for reimbursement of eligible Noble FSA expenses incurred January 1, 2021, through September 30, 2021, should be filed directly with Smart-Choice by March 31, 2022.

Step 2: Anthem determines your carryover, if any

Carryover amounts will not be available in your account until *after* June 30, 2022. Anthem will process all 2021 claims submitted by June 30, 2022, and then review the remaining 2021 HCSA account balances for employees who are eligible to receive a carryover. Anthem will automatically apply your eligible carryover amount to your account *after* June 30, 2022, as follows:

- If your 2021 HCSA account balance is **under $25**, you will not receive a carryover.
- If your 2021 HCSA account balance is **at least $25**, your remaining account balance will carry over.

example

You elected to contribute $1,000 to your 2021 HCSA account.

Expense	2021 Final account balance
You incurred **$250** in total expenses incurred between January 1 and December 31, 2021. You submitted all outstanding 2021 claims prior to June 30, 2022.	$750
Amount that will carryover to 2022. As a reminder your carryover amount will appear in your account *after* June 30, 2022:	**$750**
Amount from your 2021 HCSA that will be forfeited:	$0

Step 3: How to use your carryover

If you are enrolled in the HCSA for 2022 …

If you are enrolled in the HCSA for 2022 and you're eligible for carryover, your carryover amount will be determined after June 30, 2022, and *added to* the amount you elect to contribute to the HCSA for 2022. Your *new*, total 2022 HCSA balance must be used according to normal plan rules.

- The **2021 carryover amount,** now included in your 2022 HCSA account, can be used for:
  - Eligible expenses incurred **January 1** through **December 31, 2021**, as long as the deadline to claim 2021 expenses has not passed. The claims deadline for 2021 eligible expenses is 60 days after the President announces the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak **or** June 30, 2022, whichever occurs *later.*
  - Eligible expenses incurred **January 1** through **December 31, 2022**, as long as the deadline to claim 2022 expenses has not passed. The normal claims deadline for 2022 eligible expenses is June 30, 2023.

- Your new **2022 contributions** to your 2022 HCSA account can be used for:
  - Eligible expenses incurred **January 1** through **December 31, 2022**, as long as the deadline to claim 2022 expenses has not passed. The normal claims deadline for 2022 eligible expenses is June 30, 2023.
  - You *cannot* use new 2022 contributions to pay for eligible expenses incurred **January 1** through **December 31, 2021,** even if the claims deadline has not passed.
- Note: If you're eligible for the carryover of your 2021 HCSA, your carryover amount *does not* count toward the 2022 annual contribution maximum limit of $2,750.

example

During open enrollment, you elected to contribute **$2,750** to your 2022 HCSA account, the maximum amount allowed.	$2,750 HCSA balance on January 1, 2022.
You submit any outstanding 2021 claims by June 30, 2022. After 2021 claims are processed, Anthem determines the carryover from your 2021 HCSA to your 2022 HCSA is $750.	$750 Carryover from your 2021 HCSA to your 2022 HCSA.
You have $3,500 in your 2022 HCSA account, which now includes any carryover.	**$3,500** Total HCSA balance in July 2022, after carryover. • Your **$750 carryover** can be applied to eligible expenses incurred in 2021 *or* 2022. • Your **$2,750 in new 2022 contributions** can be applied to eligible expenses incurred in 2022 only.

If you are *not* enrolled in the HCSA for 2022 …

If you are *not* enrolled in the HCSA for 2022 and you're eligible for carryover*, your carryover amount will be applied to your existing HCSA account after June 30, 2022. Your account will remain available for you to use the carryover according to normal plan rules. You can continue to use your existing HCSA debit card, submit claims, and access your account online as you did in 2021.

- The money in your 2022 HCSA account, which now includes any carryover, can be used for:
  - Eligible expenses incurred **January 1** through **December 31, 2022**, as long as the deadline to claim 2022 expenses has not passed. The normal claims deadline for 2022 eligible expenses is June 30, 2023.
  - Eligible expenses incurred **January 1** through **December 31, 2021**, as long as the deadline to claim 2021 expenses has not passed. The claims deadline for 2021 eligible expenses is 60 days after the President announces the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak **or** June 30, 2022, whichever occurs *later.*

As a reminder, if you are enrolled in the Chevron High Deductible Health Plan (HDHP) or the Chevron High Deductible Health Plan Basic (HDHP Basic) in 2022, you still cannot also participate in the HCSA in 2022 and therefore **are not eligible for the carryover.*

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.

expanded carryover of 2020 funds

health care spending account plan

for active employees

effective january 1, 2021 through december 31, 2021

human energy. yours.™

Update to the summary plan descriptions (SPD)
Changes described in this SMM are effective January 1, 2021 through December 31, 2021.

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

introduction

This document describes an expanded carryover opportunity for unused 2020 Chevron Health Care Spending Account (HCSA) funds into 2021 as permitted by the 2021 Consolidated Appropriation Act. **These expanded rules are effective as of January 1, 2021 and remain available to Chevron Health Care Spending Account (HCSA) Plan participants through December 31, 2021, as described in this document.**

This document applies to eligible, active U.S.-payroll employees.

The HCSA has been amended as permitted by the 2021 Consolidated Appropriation Act effective January 1, 2021. **This summary material modification (SMM) contains the current plan provision changes and replaces the HCSA carryover provisions previously described in the October 1, 2020 SMM.**

Typically, the money in your HCSA can be used only for eligible expenses incurred between January 1 and December 31 in the year you are enrolled. Any remaining balance left in your account after the final claim filing deadline will be forfeited.

Due to the COVID-19 public health emergency, HCSA participants may have more unused HCSA amounts at the end of the plan year than in previous years. To address this issue, Congress and the IRS temporarily adjusted standard flexible spending account rules and requirements. **Chevron has adopted this increased flexibility effective January 1, 2021 through December 31, 2021 and Chevron Health Care Spending Account (HCSA) Plan participants now have access to increased carryover balances as described in this document.**

who is eligible for the new carryover

To be eligible for the special, one-time carryover, you must satisfy **all** of the following requirements:

- You were a U.S.-payroll employee **enrolled in the HCSA** for all or part of the 2020 plan year.
- You have **at least $25** in **unused funds** in your 2020 HCSA. There is *no* maximum limit to the amount you're permitted to carry over.
- **Important:** If you are enrolled in the Chevron High Deductible Health Plan (HDHP) or the Chevron High Deductible Health Plan Basic (HDHP Basic) in 2021, you still *cannot* also participate in the HCSA in 2021 and therefore **are not eligible** for the carryover.

what's changed?

The new changes *eliminate* some of the restrictions imposed for the one-time carryover opportunity as communicated in October 2020:

- Under previous rules you were limited to a maximum of $550 of unused HCSA funds. Under the new rules, there is *no* maximum carryover limit.
- Under previous rules you were required to enroll in and contribute a minimum of $120 to the HCSA for 2021 to receive your carryover, if any. Under the new rules, you *do not* have to be enrolled in or contribute to the HCSA in 2021 to receive your carryover, if any.

As a reminder, if you are enrolled in the Chevron High Deductible Health Plan (HDHP) or the Chevron High Deductible Health Plan Basic (HDHP Basic) in 2021, you still cannot also participate in the HCSA in 2021 and therefore **are not eligible** for the carryover. This rule has *not* changed.

reminder: claims deadline extended

As a reminder, due to the current global pandemic, the deadline to submit claims for eligible expenses incurred **January 1, 2020** through **December 31, 2020** has been extended. The deadline for 2020 claims is now **60 days** after the President announces the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak *or* **June 30, 2022**, whichever occurs first. **After the applicable claims deadline, you can no longer submit a claim for expenses incurred in 2020.**

While you have extra time to submit claims if you need it, we *strongly* encourage you to submit as many of these claims as possible prior to the normal claims deadline of June 30, 2021 to assist with processing the carryover of your 2020 HCSA (if any).

how the new carryover works

Step 1: Submit your outstanding 2020 claims.

While the claims deadline has been extended for eligible expenses incurred January 1, 2020 through December 31, 2020, you're strongly encouraged to submit claims as soon as they happen. Claims for eligible expenses submitted by June 30, 2021 will be paid from your 2020 HCSA account balance.

step one example

You elected to contribute $1,000 to your 2020 HCSA account.

Prior to adopting the carryover, the money in your 2020 HCSA could be used for eligible expenses incurred January 1, 2020 through December 31, 2020.

Expense	2020 Account balance is now …
$100 on July 8, 2020 using your HCSA debit card.	$900
$50 on September 12, 2020 using your HCSA debit card.	$850
You submit a claim form on June 10, 2021 for a $100 eligible expense incurred on March 10, 2020 that you forgot about.	$750

Step 2: Anthem determines your carryover, if any

Anthem will process all 2020 claims submitted by June 30, 2021 and then review the remaining 2020 HCSA account balances for employees who are eligible to receive a carryover. Anthem will automatically apply your eligible carryover amount, as follows:

- If your 2020 HCSA account balance is **under $25**, you will not receive a carryover.
- If your 2020 HCSA account balance is **at least $25**, your remaining account balance will carry over.

step two example

You elected to contribute $1,000 to your 2020 HCSA account.

Expense	2020 Final account balance
You incurred **$250** in total expenses incurred between January 1 and December 31, 2020. You submitted all outstanding 2020 claims prior to June 30, 2021.	$750
Amount that will carryover to 2021:	**$750**
Amount from your 2020 HCSA that will be forfeited:	$0

Step 3: How to use your carryover

If you are enrolled in the HCSA for 2021 …

If you are enrolled in the HCSA for 2021 and you're eligible for carryover, your carryover amount will be *added to* the amount you elect to contribute to the HCSA for 2021. Your *new*, total 2021 HCSA balance must be used according to normal plan rules.

- The **2020 carryover amount,** now included in your 2021 HCSA account, can be used for:
  - Eligible expenses incurred **January 1** through **December 31, 2020**, as long as the deadline to claim 2020 expenses has not passed. The claims deadline for 2020 eligible expenses is 60 days after the President announces the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak **or** June 30, 2022, whichever occurs *first.*
  - Eligible expenses incurred **January 1** through **December 31, 2021**, as long as the deadline to claim 2021 expenses has not passed. The normal claims deadline for 2021 eligible expenses is June 30, 2022.
- Your new **2021 contributions** to your 2021 HCSA account can be used for:
  - Eligible expenses incurred **January 1** through **December 31, 2021**, as long as the deadline to claim 2021 expenses has not passed. The normal claims deadline for 2021 eligible expenses is June 30, 2022.
  - You *cannot* use new 2021 contributions to pay for eligible expenses incurred **January 1** through **December 31, 2020,** even if the claims deadline has not passed.
- Note: If you're eligible for the carryover of your 2020 HCSA, your carryover amount *does not* count toward the 2021 annual contribution maximum limit of $2,750.

step three example

During open enrollment, you elected to contribute **$2,750** to your 2021 HCSA account, the maximum amount allowed.	$2,750 HCSA balance on January 1, 2021.
You submit any outstanding 2020 claims by June 30, 2021. After 2020 claims are processed, Anthem determines the carryover from your 2020 HCSA to your 2021 HCSA is $750.	$750 Carryover from your 2020 HCSA to your 2021 HCSA.
You have $3,500 in your 2021 HCSA account, which now includes any carryover.	**$3,500** Total HCSA balance in July 2021, after carryover. • Your **$750 carryover** can be applied to eligible expenses incurred in 2020 *or* 2021. • Your **$2,750 in new 2021 contributions** can be applied to eligible expenses incurred in 2021 only.

If you are *not* enrolled in the HCSA for 2021 …

If you are *not* enrolled in the HCSA for 2021 and you're eligible for carryover*, your carryover amount will be applied to your existing HCSA account. Your account will remain available for you to use the

carryover according to normal plan rules. You can continue to use your existing HCSA debit card, submit claims, and access your account online as you did in 2020.

- The money in your 2021 HCSA account, which now includes any carryover, can be used for:
  - Eligible expenses incurred **January 1** through **December 31, 2021**, as long as the deadline to claim 2021 expenses has not passed. The normal claims deadline for 2021 eligible expenses is June 30, 2022.
  - Eligible expenses incurred **January 1** through **December 31, 2020**, as long as the deadline to claim 2020 expenses has not passed. The claims deadline for 2020 eligible expenses is 60 days after the President announces the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak **or** June 30, 2022, whichever occurs *first.*

As a reminder, if you are enrolled in the Chevron High Deductible Health Plan (HDHP) or the Chevron High Deductible Health Plan Basic (HDHP Basic) in 2021, you still cannot also participate in the HCSA in 2021 and therefore **are not eligible for the carryover.*

New temporary mid-year enrollment rules may allow you to make changes to your HCSA in 2021. Learn more about these rules.

reminder: HCSA 2021 maximum annual contribution limit

For your reference, effective **January 1, 2021** the maximum amount you're allowed to contribute to the Chevron Health Care Spending Account (HCSA) is as follows:

- You can contribute up to **$2,750**.
- If you're eligible for the carryover of your 2020 HCSA, your carryover amount **does not** count toward the 2021 annual maximum; your carryover amount will be **added to** the amount you elect (if any) to contribute to the HCSA for 2021. For example, if you elect to contribute the maximum of $2,750 in 2021 and you're eligible for a 2020 HCSA carryover of $1,000, you will be eligible to spend a total of $3,750 from January 1, 2021 through December 31, 2021 under the 2021 HCSA.
- Chevron *does not* contribute to the HCSA.

who to contact

- To make mid-year HCSA enrollment or election changes, call the **HR Service Center** at **1-888-825-5247** (1-832-854-5800 outside the U.S.)
- Contact **Anthem** directly at **1-844-627-1632** to discuss reimbursement claims, eligible expenses, the HCSA debit card, or other carryover questions.
- HCSA information and claim resources are available on **hr2.chevron.com**. Go to **Health Plans** on the top navigation, then choose **Health Accounts** from the dropdown menu.

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.

new mid-year enrollment rules

health care spending account plan

for active employees

effective january 1, 2021 through december 31, 2021

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Update to the summary plan descriptions (SPD)
Changes described in this SMM are effective January 1, 2021 through December 31, 2021.

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

introduction

This document describes a temporary change regarding mid-year elections and changes for the Chevron Health Care Spending Account (HCSA) Plan as permitted by the 2021 Consolidated Appropriation Act. **These expanded rules are effective as of January 1, 2021 and remain available to Chevron Health Care Spending Account (HCSA) Plan participants through December 31, 2021, as described in this document.**

This document applies to eligible, active U.S.-payroll employees.

how it works

Typically, if you want to participate in the HCSA, you must enroll during open enrollment or within 31-days of certain qualifying life events. In addition, you cannot change your contribution election mid-year or stop participating unless you experience certain qualifying life events that allow these kinds of changes.

For the 2021 plan year, eligible employees are permitted to **change contribution elections** and **stop or start** participating in the HCSA at any time during the plan year, for *any* reason, without regard to qualifying life events or the open enrollment period.

- You must be an active employee **eligible to participate in the HCSA** to enroll. There are no changes to the current HCSA eligibility rules.
- These enrollment and contribution changes are **prospective only** and therefore cannot be applied prior to the date you actually make the election change.

- You can change your annual goal amount by **increasing**, **decreasing** or **stopping** your contributions, with the following limitations:
  - Changes to your annual goal amount **cannot be less** that what you've already contributed.
  - If your account is overspent, meaning you have claimed more reimbursements than you've contributed, you may only reduce your annual goal amount to **equal your year-to-date reimbursements**.
  - The **annual HCSA maximum** and minimum contribution limits continue to apply.
- To change your enrollment mid-year, **call the HR Service Center** for assistance; this change generally cannot be made on the BenefitConnect website.
- This temporary expansion of mid-year election rules applies to the **2021** plan year, **January 1, 2021** through **December 31, 2021**.

As a reminder, if you are currently enrolled in the High Deductible Health Plan (HDHP) or the High Deductible Health Plan Basic (HDHP Basic), you cannot also participate in the HCSA.

HCSA 2021 maximum annual contribution limit

For your reference, effective **January 1, 2021** the maximum amount you're allowed to contribute to the Chevron Health Care Spending Account (HCSA) is as follows:

- You can contribute up to **$2,750**.
- If you're eligible for the carryover of your 2020 HCSA, your carryover amount **does not** count toward the 2021 annual maximum; your carryover amount will be **added to** the amount you elect (if any) to contribute to the HCSA for 2021. For example, if you elect to contribute the maximum of $2,750 in 2021 and you're eligible for a 2020 HCSA carryover of $1,000, you will be eligible to spend a total of $3,750 from January 1, 2021 through December 31, 2021 under the 2021 HCSA. See the Carryover plan change information for additional details.
- Chevron *does not* contribute to the HCSA.

who to contact

- To make mid-year HCSA enrollment or election changes, call the **HR Service Center** at **1-888-825-5247** (1-832-854-5800 outside the U.S.)
- Contact **Anthem** directly at **1-844-627-1632** to discuss reimbursement claims, eligible expenses, the HCSA debit card, or other questions.
- HCSA information and claim resources are available on **hr2.chevron.com**. Go to **Health Plans** on the top navigation, then choose **Health Accounts** from the dropdown menu.

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.

extended claims deadline for 2020 expenses

health care spending account plan

effective january 1, 2021 through december 31, 2021

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Update to the summary plan descriptions (SPD)
Changes described in this SMM are effective January 1, 2021 through December 31, 2021.

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

how it works

Under normal Health Care Spending Account (HCSA) plan rules, June 30, 2021, is your last chance to submit claims for reimbursement of eligible expenses incurred January 1, 2020 through December 31, 2020.

As a reminder, due to the current global pandemic, the deadline to submit claims for eligible expenses incurred **January 1, 2020** through **December 31, 2020** has been extended. The deadline for 2020 claims is now **60 days** after the President announces the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak *or* **June 30, 2022**, whichever occurs first. **After the applicable claims deadline, you can no longer submit a claim for expenses incurred in 2020.**

While you have extra time to submit claims if you need it, we *strongly* encourage you to submit as many of these claims as possible prior to the normal claims deadline of June 30, 2021 to assist with processing the carryover of your 2020 HCSA (if any).

who to contact

- To make mid-year HCSA enrollment or election changes, call the **HR Service Center** at **1-888-825-5247** (1-832-854-5800 outside the U.S.)
- Contact **Anthem** directly at **1-844-627-1632** to discuss reimbursement claims, eligible expenses, the HCSA debit card, or other carryover questions.
- HCSA information and claim resources are available on **hr2.chevron.com**. Go to **Health Plans** on the top navigation, then choose **Health Accounts** from the dropdown menu.

annual contribution limit

health care spending account plan

effective january 1, 2021

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Update to the summary plan descriptions (SPD)
Changes described in this SMM are effective january 1, 2021.

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

maximum annual contribution limit

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

Effective **January 1, 2021** the maximum amount you're allowed to contribute to the Health Care Spending Account (HCSA) is increasing:

- You can contribute up to **$2,750**.
- If you're eligible for the carryover of your 2020 HCSA, your carryover amount **does not** count toward the 2021 annual maximum; your carryover amount will be **added to** the amount you elect to contribute to the HCSA for 2021. For example, if you elect to contribute the maximum of $2,750 in 2021 and you're eligible for the maximum 2020 HCSA carryover of $550, you will be eligible to spend a total of $3,300 from January 1, 2021 through December 31, 2021 under your 2021 HCSA.
- Chevron *does not* contribute to the HCSA.

contact

More HCSA information and claim resources are available on hr2.chevron.com. Go to **Health Plans** on the top navigation, then choose **Health Accounts** from the dropdown menu. Contact **Anthem** directly at **1-844-627-1632** to discuss reimbursement claims, eligible expenses, or the HCSA debit card.

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.

deadline extended to submit claims for 2019 flexible spending account expenses

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

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

Under normal Health Care Spending Account (HCSA) plan rules, June 30, 2020, is your last chance to submit claims for reimbursement of eligible expenses incurred on or before December 31, 2019.

Due to the current global pandemic, the deadline to submit claims has been extended to 60 days after the President announces the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak.

While you have the extra time if you need it, we strongly encourage you to submit your 2019 claims as soon as possible, if you haven't already done so.

Please keep in mind that your Chevron flexible spending account plans do not have a *grace period* or *carryover* feature, so this means you can only submit a claim for reimbursement of eligible expenses you incurred by December 31, 2019.

how to submit a claim

You'll need to submit a claim for reimbursement for those transactions in which you couldn't use the special purpose HCSA debit card (if any). If you miss the extended claims deadline, you will not be reimbursed, and any remaining funds in your 2019 account will be forfeited. As a reminder, **HealthEquity** was the claims administrator for your 2019 account(s).

- **Paper claim forms** | Access the **Forms Library** on **hr2.chevron.com/document-library/forms**
- **Online claims** | Access your HealthEquity account at **my.healthequity.com**

have questions?

If you have any questions about your 2019 account or need help filing a claim, contact HealthEquity:

- **Phone** 1-866-346-5800
- **Email** memberservices@healthequity.com

Chevron U.S. Benefits

update to expenses covered

health care spending account plan

effective January 1, 2020

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

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

expenses covered

nonprescription (over-the-counter) medication and products

Generally, expenses qualified for reimbursement under the **HCSA** are out-of-pocket medical, dental, vision or hearing expenses for you or an eligible dependent and are generally of the type that would qualify for deduction on your federal income tax return. In addition, certain *prescribed* over-the-counter medications may be considered qualified expenses. In accordance with the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) the HCSA has been amended to provide that effective **January 1, 2020** certain nonprescription (over-the-counter) medicines and other products may be considered qualified expenses under the HCSA as follows:

- Purchases of **over-the-counter medicines,** that had previously required a prescription to be considered qualified expenses, for example Aspirin, Advil, Excedrin, Aleve, cough medicine and similar products.
- Expenses incurred for **menstrual care products** – such as tampon, pad, liner or similar product are considered an expense qualified for reimbursement.
- Expenses for qualified over-the-counter medicines and menstrual care products bought since **January 1, 2020** and while you're a plan participant are eligible for reimbursement.
- As a reminder, expenses reimbursed or paid under any other benefit plan or arrangement, including another employer's group health plan, are not eligible for reimbursement under the HCSA.

Anthem and retailers who sell these products are currently updating their systems to include these products as an expense qualified for reimbursement. This means that you may not be able to use your special purpose HCSA debit card to pay for these products until all systems have been updated. In these situations, you'll need to pay for the product out-of-pocket and submit a claim to Anthem for reimbursement. Additional instructions and a claim form are available on **hr2.chevron.com**.

contact

More HCSA information and claim resources are available on hr2.chevron.com. Go to **Health Plans** on the top navigation, then choose **Health Accounts** from the dropdown menu. Contact **Anthem** directly at **1-844-627-1632** to discuss reimbursement claims, eligible expenses, or the special purpose HCSA debit card.

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.

new fee for insufficient funds

effective January 1, 2019

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Update to the summary plan descriptions (SPD)
All changes described in this SMM are effective January 1, 2019 unless otherwise indicated.

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

new fee for insufficient funds

Effective January 1, 2019, Chevron will adopt a new standard process regarding the payment of benefit premiums. This policy applies if you are being billed directly for your Chevron benefit premiums. If your payment is rejected due to insufficient funds in your bank account, a fee will be assessed to your account. You'll be required to ensure timely payment of the outstanding balance, including the fee, is received by the Chevron HR Service Center prior to the deadline to continue your benefit coverage.

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new qualifying life event

health plans

effective January 1, 2019

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Update to the summary plan descriptions (SPD)
All changes described in this SMM are effective January 1, 2019 unless otherwise indicated.

The enclosed information serves as an official summary of material modification (SMM) for all Chevron medical plans including the **Medical PPO Plan, High Deductible Health Plan, High Deductible Health Plan Basic,** all **Medical HMO Plans,** and the **Global Choice Plan (U.S.-Payroll Expatriate)**. 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 / hr2.chevron.com/retiree** or by calling the HR Service Center at **1-888-825-5247**.

new qualifying life event

A qualifying life event is an event that allows eligible benefit plan participants to make certain changes to benefit coverage, such as starting or stopping coverage, adding or dropping dependents, and increasing or decreasing coverage. Examples of current qualifying life events for Chevron employee health benefits include getting married or divorced, having or adopting a dependent child, or moving outside the service area of your health coverage.

Effective January 1, 2019, a new event has been added as an eligible qualifying life event for Chevron health benefits:

- You, your spouse or domestic partner, or your dependent child enroll in the federally-facilitated Health Insurance Marketplace or a state-based Marketplace.

If you or your enrolled dependents encounter this qualifying life event, you will have 31 days from the date of the event to report the qualifying life event to the HR Service Center and drop your current Chevron health coverage.

This qualifying life event doesn't apply to the private health exchange offered to Chevron post-65 eligible retirees through ViaBenefits. Go to **HealthCare.gov** for more information about the Health Insurance Marketplace.

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benefit contact information

This summary plan description refers you to contact the administrators listed below.
Please refer to this section for phone numbers, website and other key contact information.

Anthem Blue Cross

Claims administrator for the Health Care Spending Account Plan.

Why contact this administrator

- Ask questions about your plan coverage.
- Ask about qualifying expenses that are eligible for reimbursement.
- Get account balance information.
- Submit claims for reimbursement of a qualifying expense.

Phone information

- Phone (Inside U.S.) 1-844-627-1632
- Phone (Outside U.S.) 1-844-627-1632

Website information

- Check your account, review or manage claims.
- **anthem.com/ca**

Other contact information

- **Sydney Health app** mobile app available on the Apple App Store or Google Play.

Chevron Benefits HR2 Website

Why access this website

- Access summary plan descriptions (SPDs).
- Access benefit information and documents.
- Get benefit phone numbers and access websites referenced in this summary plan description.

Website information

- You don't need a password to access the information posted on this website.
- **hr2.chevron.com** as an employee.

Human Resources Service Center (HR Service Center) *and* Benefits Connection Website

Why contact this administrator

- Enroll in this plan.
- Make open enrollment elections for this plan.
- Ask about your or your dependents' eligibility to participate in this plan.
- Report qualifying life events – such as a marriage, divorce, birth or death.
- Request a printed copy of summary plan descriptions (SPD).

Phone information

- 1-888-825-5247 (1-832-854-5800 outside the U.S.)
- 5 a.m. - 6 p.m. Pacific time (7 a.m. - 8 p.m. Central time)

Mailing Address
Department: CVXH
P.O. Box 981901
El Paso, TX 79998

Website information

- **BenefitConnect** website for personal benefit information and conduct certain transactions, such as updating your beneficiaries, view your current enrollments and costs, enroll in Chevron benefits, make benefit changes or make open enrollment elections, choose your communication preferences.
- As an employee, go to **hr2.chevron.com** and click the **BenefitConnect** link.
- If you have access to a Chevron workstation connected to the GIL computing network, you can use the automatic login feature; you don't need a password to access the BenefitConnect website.
- If you don't have access to a Chevron workstation connected to the GIL computing network, you will need to enter your BenefitConnect user ID and passcode; automatic login is not available. Follow the instructions on the BenefitConnect login screen if you need to register to use the website or if you don't remember your user ID and passcode.

Summary Plan Descriptions

Summary Plan Descriptions (SPDs) provide detailed information about your Chevron benefit plans such as eligibility, claims and participation.

- Go to **hr2.chevron.com** as an employee.
- You can also call the HR Service Center to request that a copy be mailed to you, free of charge.

BenefitConnect | COBRA

Claims administrator for COBRA continuing coverage for Chevron health plans.

Why contact this administrator

- To enroll in COBRA or continuation coverage for Chevron health plans and wellness programs when you leave Chevron.
- To learn about COBRA or continuation coverage.
- To ask about COBRA or continuation coverage monthly costs.
- To update COBRA or continuation coverage.
- To manage monthly premium payments for COBRA or continuation coverage.
- For information about the COBRA law.

Phone information

- **1-877-292-6272** (**1-858-314-5108** outside the U.S.)
- Monday through Friday
- 6:00 a.m. to 4:00 p.m. Pacific Time (8:00 a.m. to 6:00 p.m. Central Time) excluding holidays

Website information

- Enroll, view current coverage and cost, sign up for Auto Pay, make a one-time ACH payment.
- You will receive a user ID and login instructions in your personal COBRA enrollment notice.
- **https://cobra.ehr.com**

description of the plan

overview

- **Anthem Blue Cross (Anthem)** is the claims administrator for this benefit effective January 1, 2020.

- You can use the Health Care Spending Account (HCSA) Plan to pay certain health care expenses with before-tax dollars, which means you save money.

- If you participate in the Chevron High Deductible Health Plan (HDHP) or Chevron High Deductible Health Plan Basic (HDHP Basic), then you cannot participate in the Health Care Spending Account.

- The Health Care Spending Account can reimburse health-related charges for you and your eligible dependents that satisfy all the following requirements:
  - Are not reimbursed under a health, dental or vision care plan.
  - Are the types of expenses that you could claim as a tax deduction.
  - Are incurred during the plan year in which you participate in the Health Care Spending Account.

- If you enroll in the Health Care Spending Account, the amount of before-tax contributions you authorize is deducted from your pay in equal amounts throughout the year and credited to your Health Care Spending Account.

- You can elect to contribute up to $2,700 to your Health Care Spending Account in 2020. Chevron does not contribute to this plan.

- After you incur eligible health care expenses during the plan year, you file a claim for reimbursement of your expenses with the claims administrator.

- This Plan has been set up according to provisions of the Internal Revenue Code, which include strict rules. For example, if you don't have enough qualified expenses to use all of the money you put into your plan account, you'll forfeit money that's left over after the end of the year. You also can be reimbursed for qualified expenses up to the total amount of your annual election, even if you have not yet contributed that amount for the year.

eligibility

Eligible Employee

Except as described below, you're generally eligible for the Health Care Spending Account 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 plans.

However, you're still 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 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 a professional intern.

If you're eligible to receive benefits from the **Chevron International Healthcare Assistance Plan (IHAP)**, you're not eligible for this benefit.

Non-U.S.-payroll expatriates working in the United States that are eligible for the **Global Choice Plan (Expatriates in the U.S.)** while on expatriate assignment are not eligible for this benefit.

You cannot participate in the Heath Care Spending Account (HCSA) at the same time you participate in the Chevron High Deductible Health Plan (HDHP) or the Chevron High Deductible Health Plan Basic (HDHP Basic).

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, you should contact the Chevron Human Resources Service Center.

Eligible Dependent

Under the Health Care Spending Account, an eligible dependent whose expenses can be reimbursed includes any person you can declare as a dependent on your federal income tax return for the year. This person does not have to be enrolled as a dependent under any company-sponsored benefit plan.

Note: Federal tax law does not permit you to claim expenses for your domestic partner or your domestic partner's children, unless they qualify as dependents on your federal income tax return for the year.

participation

When You Can Enroll

If you're eligible, you can enroll in the Health Care Spending Account at any of the following times:

- During open enrollment.
- During the first 31 days after you become an eligible employee.
- During the first 31 days after a qualifying life event.

You enroll in this plan for one calendar year at a time. You must re-enroll in this plan every year to continue your participation.

How to Enroll

To enroll in the Health Care Spending Account, you must contact the HR Service Center or enroll on the BenefitConnect website. When you enroll, you authorize the company to deduct before-tax contributions from your pay. Before you enroll, you should carefully review the HCSA description. In addition, it may be a good idea to consult with your personal tax adviser to make sure this plan is a good option for you. **If you are hired after December 1, then the Chevron HR Service Center will not process your enrollment for the calendar year of your hire date.**

Making Changes

During open enrollment held in the fall, you can enroll or re-enroll for the upcoming year and change your HCSA elections. Otherwise, you can't change your plan elections, unless you experience a qualifying life event. See the **Changing Your Contributions** section of this summary plan description for more information.

When Participation Begins

If you enroll in the Health Care Spending Account Plan during open enrollment, your participation begins the following January 1. If you enroll within your first 31 days of work at Chevron, your participation begins on your date of hire.

If you experience a qualifying life event, you must contact the HR Service Center within 31 days of your life event.

Your contributions are withheld from your pay starting with the first pay period after your enrollment effective date.

When Participation Ends

If you don't re-enroll in the plan during open enrollment, then your participation stops at the end of the calendar year. If you are a participant in the Health Care Spending Account and you experience a qualifying life event at any other time of the year, you can increase or decrease your contributions for the remainder of the year, as long as the change is consistent with the event.

Participation in the Health Care Spending Account also ends when you've been on a **leave of absence without pay for more than 31 days**. You can continue coverage until the end of the plan year by paying the required contributions. Contributions are on an after-tax basis while you're on leave. You will receive billing information from the HR Service Center for COBRA continuation coverage, depending on the type

of leave. If you don't continue coverage while on leave, you can re-enroll when you return from leave — your participation *does not* automatically resume.

Participation also ends when your **employment ends**. If you leave the company, you can continue to request reimbursement of qualified expenses incurred prior to the time your employment ends, up to the total amount that you had agreed to contribute for the year less any payments you have already received. However, you can't be reimbursed for expenses incurred at a time when you weren't making plan contributions. If you want to be eligible to claim expenses for the rest of the year, you must elect to continue participation under COBRA on an after-tax basis for the remainder of the plan year. The HR Service Center will send you information about continuing the Health Care Spending Account after your employment ends. For information regarding your continuation coverage rights, review the **Continuation Coverage and COBRA Coverage** chapter of this summary plan description.

If you **die**, your survivors can continue to request reimbursements for qualified expenses incurred prior to your death.

Reimbursement requests must be sent in no later than June 30 of the year after the year in which you incur the eligible expense.

how the plan works

Enrollment and Other Plan Changes

If you want to participate in the Health Care Spending Account Plan, you have to meet the Plan's eligibility requirements. To continue participation in this plan, you must re-enroll during the open enrollment period each year; your enrollment during any plan year ends after December 31 of that year. You can't enroll or make changes at any other time, unless you experience a qualifying life event that allows for enrollment or a change in your participation in this plan.

Your Contributions

When you enroll, you authorize Chevron to deduct money from your pay in equal amounts throughout the year and credit it to a Health Care Spending Account set up in your name. Your contributions are not subject to any of the following:

- Federal income taxes.
- Social Security (FICA) taxes.
- In many cases, state and local income taxes.

Before you enroll, it's very important that you determine how much money you want deducted from your pay before you enroll. This is because federal law states that you can't change or stop your deductions after they begin, unless you experience a qualifying life event during the year.

Reimbursement of Eligible Expenses

- Pay your eligible health expenses, either with your **special purpose flexible spending account debit card**, or through other means.
- If you did not use your special purpose debit card, you'll need to submit a claim to the plan's claims administrator to reimburse your eligible expense(s).
- Submit supporting documentation for the eligible expense along with your claim. The supporting documentation must include the dates of service, the services that were received and the cost.
- You can submit a claim by using the **paper form**, on the claims administrator's **website**, or by using the **mobile app**.

You can claim up to the amount you elected during the year, less prior reimbursements, regardless of your year-to-date contributions.

The amount of your withdrawal request must be at least $25. If your qualified expenses are less than $25, you should not submit a withdrawal request until you incur additional qualified expenses totaling $25 or more.

Reimbursement requests must be sent in no later than June 30 of the year after the year in which you incur the expense. Any balance remaining after June 30 will be forfeited. This money is not available for future expenses or a refund.

Administrative Fees

If you participate in the Health Care Spending Account (HCSA), you may be charged a reasonable administrative fee – deducted directly from your HCSA – for the situations below. Contact the claims administrator for information about these fees.

- **Reimbursement by a paper check** mailed to your address of record.
- For a **hard-copy monthly statement** showing your account balance mailed to your address of record. There is no charge to access monthly statements electronically.
- For a **stop-check request**.
- For additional or replacement **flexible spending account debit cards**. The first three additional or replacement debit cards are free.

qualified expenses

Expenses Covered

Generally, expenses qualified for reimbursement under the Health Care Spending Account are out-of-pocket medical, dental, vision or hearing expenses for you or an eligible dependent and are generally of the type that would qualify for deduction on your federal income tax return. In addition, certain prescribed over-the-counter medications may be considered qualified expenses.

Only expenses for goods bought or services provided during the calendar year *while you're a participant* are eligible for reimbursement. These expenses include your deductible, copayment and other out-of-pocket expenses under your group health plans.

The following are examples of covered expenses under the Health Care Spending Account Plan. For a complete list of items that may be considered qualified expenses or exclusions under the plan, call or access the claims administrator's website.

- Deductibles and copayments.
- Testing and exams not covered under your health plan.
- Abortion
- Acupuncture.
- Alcoholism treatment.
- Ambulance service.
- Artificial limbs.
- Birth control pills.
- Braille books and magazines.
- Chiropractor's fees.
- Christian Science practitioner's fees.
- Contact lenses and supplies.
- Crutches.
- Dental treatment.
- Eyeglasses, including examination fees.
- Fertility enhancement.
- Guide dogs.

- Hearing aids and batteries.
- HMO copayments.
- Hospital fees.
- Laboratory fees.
- Laser eye surgery.
- Learning disability fees.
- Legal fees that are necessary to authorize treatment for mental illness.
- Medical services.
- Nursing home expenses for medical treatment, including meals and lodging.
- Nursing services.
- Organ transplants.
- Orthodontia, except care for cosmetic purposes.
- Prescription drugs.
- Psychiatric care.
- Smoking cessation plans.
- Speech therapy.
- Sterilization.
- Surgical fees.
- Special telephone equipment for the hearing-impaired (cost and repair).
- Transplants.
- Transportation expenses primarily for and essential to medical care.
- Vasectomy.
- Weight-loss plans for the treatment of a specific existing disease diagnosed by a physician.
- Wheelchairs.
- X-ray fees.

Expenses Not Covered

The following items are examples of expenses that are not eligible for reimbursement under the Health Care Spending Account Plan. For a complete list of items that may be considered qualified expenses under the plan, call or access the claims administrator's website

- Baby-sitting, childcare and nursing services for a normal, healthy baby.
- Controlled substances.
- Elective cosmetic surgery.
- Dancing lessons.
- Diaper service.
- Electrolysis or hair removal.
- Funeral expenses.
- Future medical care.
- Hair transplant.
- Health club dues.
- Health coverage tax credit.
- Health savings account (HSA).
- Household help.
- Illegal operations and treatments.
- Insurance premiums.
- Long-term care expenses or premiums for long-term care insurance.
- Maternity clothes.
- Medical savings account (MSA).
- Medicines and drugs illegally brought in (or ordered shipped) from a country outside the United States.
- Nonprescription ("over-the-counter") medication
- Nutritional supplements.
- Personal-use items.
- Swimming lessons.
- Teeth whitening.
- Veterinary fees.
- Weight-loss plans if the purpose of the weight loss is the improvement of appearance, to maintain general health or sense of well-being.
- Expenses you have before your participation in the Health Care Spending Account begins or after it ends.
- Expenses reimbursed or paid under any other benefit plan or arrangement, including a Spouse's group health plan or a Dependent's group health plan.

your contributions

The chart below shows the current minimum and maximum amounts you can contribute to your Health Care Spending Account for the 2020 calendar year:

	Minimum Calendar-Year Contribution	Maximum Calendar-Year Contribution
Health Care Spending Account	$120	$2,700

If you and your spouse are both Chevron employees, each of you can direct up to $2,700 to a Health Care Spending Account each calendar year. If your spouse has a Health Care Spending Account with another employer, you can still contribute up to $2,700 each year.

When you enroll in the plan, you must elect how much you want to direct to the account. The choices you make when you enroll are irrevocable for the year, unless you experience a qualifying life event that allows you to make a change. You cannot redirect the amount designated on your enrollment for the Health Care Spending Account to the Dependent Day Care Spending Account, or vice versa, for any reason during the year.

In addition, funds in your Health Care Spending Account can't be used to pay for dependent care expenses. Similarly, funds in your Dependent Day Care Spending Account can't be used to pay for health care expenses. If you have a balance in either account at any time, you can't transfer those funds from one account to the other.

Note: If you're a new employee and your hire date is *before* December 1, you can have the maximum amount deducted from your pay during the year in which you join the company, no matter when you're hired.

It's very important for you to carefully estimate your calendar year expenses before deciding how much to contribute to the Health Care Spending Account. The money in your account(s) can be used only for eligible expenses incurred between January 1 and December 31 (or between the dates your participation for the calendar year begins and ends, if different). Reimbursement requests must be sent in no later than June 30 of the year after the year in which you incur the expense. Any balance remaining after June 30 will be forfeited.

If your hire date is after December 1, the HR Service Center won't process enrollments or changes for the current calendar year. This is because requests to raise or lower contribution amounts become effective on the first day of the month after you notify the HR Service Center that you want to change your contribution amount. If you notify the HR Service Center after December 1, the first day of the following month would be the first day of a new calendar year.

taxes

The amount you contribute to the Health Care Spending Account (HCSA) reduces your taxable income — meaning you pay less in taxes. Your contributions are not currently subject to any of the following:

- Federal income taxes.
- Social Security (FICA) taxes.
- In many cases, state and local income taxes.

Tax-Exempt Contributions and Social Security

Your Social Security benefits may be slightly lower at retirement if you participate in the Health Care Spending Account. This is because deductions under the plan lower your taxable Social Security wages, and your Social Security benefits are based on your taxable wages.

For example, the 2020 Social Security wage base is $137,700, and may change each year. Your Social Security benefits may be slightly lower if your annual earnings are under $137,700 after you subtract all before-tax contributions for this plan, the Dependent Day Care Spending Account, Voluntary Group Accident Insurance, and medical and dental plan coverage.

Your Social Security benefits won't be affected if your earnings are above the Social Security wage base after you subtract all before-tax contributions under this plan and the other plans noted above.

Health Care Spending Account vs. the Income Tax Deduction

When you consider whether or not to enroll in the General Purpose Health Care Spending Account, you need to consider whether you're eligible to take the federal income tax deduction for health care expenses on your income tax return.

Under current tax laws, health care expenses are normally deductible on your federal income tax return only if they exceed a certain percent of your adjusted gross income specified by the tax rules. IRS *Publication 502* available at **www.irs.gov** provides more information about expenses that are deductible for income tax purposes.

If you're not eligible for the federal income tax deduction, the Health Care Spending Account will provide tax savings on your health care expenses. However, when you use your Health Care Spending Account to reimburse expenses, you give up the opportunity to take a tax deduction for these same items because, for tax purposes, they are considered paid by the company rather than by you.

If you are eligible for the income tax deduction, either the Health Care Spending Account or the federal deduction may provide greater tax savings, depending on your situation and the amount and type of your expenses. Please see a tax adviser to determine which approach provides the greatest tax savings for you.

claims for reimbursement

You have until June 30 of the year after the year in which you incur the expense to file a claim for reimbursement. Any balance remaining after June 30 will be forfeited. You can submit a claim as often as you like, but the amount of your claim must be at least $25.

How to Submit Claims

There are up to three ways to file Health Care Spending Account claims.

- Use your special purpose debit card.
- Complete an online claim from the claims administrator's website.
- Use the claims administrator's mobile app.
- Complete a paper claim form.

A Health Care Spending Account claim form is available from the **Forms Library** on **hr2.chevron.com** or by calling or accessing the claims administrator's website. Instructions for returning the claim are included on the form.

Special Purpose Debit Card

A special purpose debit card will be issued to you for use on qualified health care expenses. This card provides instant access to your Health Care Spending Account. The card is designed for use only at qualified providers or merchants with the Inventory Information Approval System (IIAS) swipe technology and offer eligible goods or services for reimbursement under your Health Care Spending Account. Keep your cards even if you've used your entire account balance; just like your bank debit card they can be reused if you participate again next year. New cards for existing members will not be reissued, unless your card is set to expire during the year.

No claim forms are required. Swipe your card and the special purpose debit card transfers funds for qualified expenses directly from the available funds in your Health Care Spending Account to the provider in either partial or whole amounts. You can only use the card to pay for eligible expenses, up to your account balance.

In general, you do not have to submit receipts for reimbursement as long as the purchases are made at a participating retailer and you use your special purpose debit card. However, there are some circumstances in which substantiation will be required; the claims administrator will notify you if this applies to you. In all cases, IRS guidelines still require you to save your itemized receipts as part of your tax records. Please be advised that when using your card, you are certifying use for qualified health care expenses.

If this is your first time to participate in the Health Care Spending Account (HCSA), you will automatically receive a debit card.

The debit card can only be used for purchases inside the United States, so if you incur an expense outside the U.S., you'll need to submit a claim form (online, with the app or by paper) to request reimbursement.

Call the claims administrator if you have questions, have lost your cards, or have not received your cards.

Documentation You'll Need

When you file an online, mobile app or paper claim, you must include documentation supporting your request for reimbursement of your qualified health care expenses. The documentation must show when the care was provided and how much it cost. If you're filing a claim for a prescribed over-the-counter medication, you must include an itemized receipt that clearly shows the type and cost of the medication purchased. The name of the medication must be printed on the receipt; a handwritten notation is not sufficient documentation. When you file a claim for an over-the-counter medication, you can also be reimbursed for sales tax if you include the value of the sales tax on the claim form.

How Reimbursements Are Received

The claims administrator processes reimbursement requests within 3-5 business days. Each time expenses are reimbursed; you'll receive communication from the claims administrator describing activity within your account and your account balance. Reimbursements are available by check or through an electronic funds transfer (EFT).

Checks

Checks are mailed three business days after claims are processed.

Electronic Funds Transfer (EFT)

You can arrange to receive your reimbursements through an electronic funds transfer (EFT) directly to your bank account. Contact your **claims administrator** or access the **HCSA** page on **hr2.chevron.com** for direct deposit setup instructions.

Once an electronic funds transfer is in effect, your reimbursements are deposited directly to your bank account generally 2-3 business days after your claim forms are processed.

claim reviews and appeals

The plan has a claim review process that is followed whenever you submit a claim for benefits. 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 in this chapter of this summary plan description.

Initial Review and Decision

When you file a claim, the claims administrator 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 frames described in the chart below.

Time Limits	
Plan notice of initial claim decision	1. **Not later than 30 days** after receiving your 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 45days total. If an extension is needed, you will be notified within the initial 30 days. 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 you will have until plan year end to provide additional information requested. A decision will be made within 15 days after receiving your additional information or, after your 45-day deadline to complete the claim, whichever is earlier.

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 frames described in the chart above.

If your claim is approved, benefits will be paid to you.

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

If Your Claim Is Denied

If your claim is denied (in whole or in part), you will receive a written notice that includes:

- 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 to file a civil lawsuit under section 502(a) of ERISA following an adverse determination on appeal).

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, your 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 circumstance. Alternatively, your 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 Appeal

After receiving the notice of denial, you can 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 specified in the Time Limits chart in this section.

During the time limit for requesting an appeal, you or your authorized representative will be given reasonable access to all documents and information relevant to the claim, and you can request copies free of charge.

Your appeal should include all of the following:

- The patient's name.
- The date(s) of health care service(s).
- The provider's name.
- An explanation of why you believe the claim should be paid.
- Claims appeal form.

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

Time Limits	
Your deadline to request an appeal	180 days after receiving claim denial notice
Plan notice of appeal decision	Not later than 60 days after receiving an appeal

Where to Send Your Appeal

Send your appeal to the claims administrator at:

Anthem Appeals
P.O. Box 54159
Los Angeles, CA 90054-0159

The claims administrator 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.

Time Limits and Procedures for Processing Your Appeal

Upon receipt of your complete 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 review will be completed within the time frame shown in the chart above.

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 neither is the individual who initially denied the claim that is the subject of the appeal, nor is the subordinate of such individual.
- If your claim is denied on appeal and such denial is 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 neither is an individual who was consulted in connection with the denial of the claim that is the subject of the appeal nor is the subordinate of such individual.
- Upon your request, the claims administrator will identify the 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.

Notice of Decision on Appeal

If 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.

If your appeal is denied, you will receive a written notice. 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.

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, your 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 circumstance. Alternatively, your notice will include a statement that such explanation will be provided to you free of charge upon request.

Administrative Power and Responsibilities

Chevron Corporation has the discretionary authority to control and manage the administration and operation of the Health Care Spending Account. 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.

how to file a claim for eligibility

If you have a question regarding your eligibility to participate in the Health Care Spending Account Plan contact the HR Service Center. 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 in the HCSA, 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
Chevron Corporation Health Care Spending Account Plan
Department: CVXH
P.O. Box 981901
El Paso, TX 79998

If you file a claim for participation in the HCSA, 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 in the HCSA 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 HCSA 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 in the Health Care Spending Account

If your claim for participation in the Health Care Spending Account 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 the HCSA documents, records and other information relevant to your claim for participation in the HCSA.

The Review Panel will provide you with a written response to the appeal and will either reverse the earlier decision and permit participation in the HCSA, 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 HCSA provisions or Chevron policy on which the denial is based.
- Information explaining your right to review and receive, at no charge, copies of the HCSA documents, records and other information relevant to your claim for participation in the Health Care Spending Account.
- 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 Health Care Spending Account provisions or Chevron policy or to grant exceptions to the HCSA rules or Chevron policy.

For appeals regarding participation in the HCSA, address your written correspondence to:

Review Panel
Chevron Corporation Health Care Spending Account 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.

changing your contributions

Your before-tax contributions to the Health Care Spending Account stop automatically if you're no longer a regular full-time employee or part-time employee who works one of the approved part-time schedules, or if you're on a leave of absence without pay. You can, however, continue participation by electing COBRA for the remainder of the plan year. You would then make manual after-tax payments. If you continue to participate by making such after-tax payments, you can continue to submit claims incurred during the remainder of the plan year.

Federal law does not allow you to change your plan contributions during the year — unless you experience a qualifying life event. Moreover, the change you request must be consistent with the event.

If your hire date is after December 1, the HR Service Center won't process enrollments or changes for the current calendar year. This is because requests to raise or lower contribution amounts become effective on the first day of the month after you notify the HR Service Center that you want to change your contribution amount. If you notify the HR Service Center after December 1, the first day of the following month would be the first day of a new calendar year.

Qualifying Life Events

The following life events may qualify you to make appropriate changes in your Health Care Spending Account elections. A qualifying life event is any of the following circumstances that may affect eligibility for coverage:

- You get divorced or legally separated or you have your marriage annulled.
- Your spouse or dependent child dies.
- Your child attains age 26.
- You get married.
- You have a baby, adopt or have a child placed with you for adoption, or you acquire another eligible dependent child.
- Your work schedule changes from part-time to full-time or vice versa or you commence or return from an unpaid leave of absence of more than 31 days.
- Your spouse starts or stops working.

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 after the event that necessitates the change. If you don't, you can't make a coverage change until the next open enrollment, unless you have another qualifying life event.

if you go on a leave of absence

Here's what happens if you take a leave of absence after you start making contributions to this plan.

- **If you're on a leave of absence with pay:** Your plan contributions continue during your leave.
- **If you're on a leave of absence without pay for 31 days or less:** Your missed contributions will be deducted from your paycheck when you return to work.
- **If you are called to active military duty for a period of at least 180 days:** You are able to request a Qualified Reservist Distribution (QRD). The QRD allows you (if enrolled in the Health Care Spending Account) to request the amount contributed to the HCSA as of the date of the QRD minus the reimbursements received as of that date. A copy of your order to call to active duty must be received before the QRD is paid out. Upon QRD pay out, your right to submit claims and participate in the plan will be terminated. The request must be made between the date of order to call to active duty and ending on the last day of the plan year for a QRD. This payout will be made within 60 days from the date of the request. In order to make this request you will need to contact the HR Service Center.
- **If you're on a leave of absence without pay for more than 31 days:** Participation in the Health Care Spending Account ends when you've been on a leave of absence without pay for more than 31 days. You can continue participation in the Health Care Spending Account until the end of the current year on an after-tax basis by electing COBRA and paying a 2 percent administrative fee. After your leave begins, you'll receive information about electing COBRA continuation coverage from the HR Service Center, the company that handles Chevron's COBRA administration. Because your contributions are on an after-tax basis, while you're on leave you won't have a tax savings on your contributions, but you're able to claim expenses incurred while you're on leave. For information regarding your continuation coverage rights, review the **COBRA and Continuation Coverage** chapter of this summary plan description.
- If you do not elect COBRA continuation coverage during your leave, you cannot claim expenses incurred during your leave, even if you re-enroll when you return. And, even if you return from leave in the same calendar year, you need to re-enroll; the plan does not restart automatically.
- If you do not continue participating while on leave and you return in the same calendar year, you can do one of the following:
  - Re-enroll for the original annual amount. Deductions are redistributed over the remaining pay periods in the year.
  - Re-enroll at a reduced amount. The new amount can't be less than the amount already deducted before your leave.
  - Choose not to re-enroll.

If you're on leave of absence during open enrollment, you can't enroll in the Health Care Spending Account for the following year. You can make a new election when you return from leave.

Special rules apply if you take a **Family Leave** or **Disability Leave**. If you continue to participate while you're on leave, you aren't charged the COBRA administrative fee. The HR Service Center will bill you for your after-tax contributions. You are responsible for making timely payments of your contributions as defined by the administrative rules of the plan. To avoid cancellation of coverage because of a late or missed payment, please call the HR Service Center within 31 days of your leave if you don't receive information regarding the billing of your contributions.

If you're on leave during open enrollment, you can sign up for the Health Care Spending Account for the next year, with billing starting in January (on an after-tax basis). Paycheck deductions start when you return from leave. Or, you can wait until you return from leave to enroll.

other plan information

Administrative Information
HIPAA
Your ERISA Rights

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 is 94-0890210.

Plan Sponsor and Plan Administrator

Chevron Corporation is the plan sponsor and administrator and can be reached at the following address:

Chevron Corporation
P.O. Box 6075
San Ramon, CA 94583-0767

Chevron Corporation Health Care Spending Account

Plan number: 840

Claims Administrator:
Anthem Blue Cross Claims │ PO Box 161606 │Altamonte Springs, FL 32716

Type of Administration: Contract Administration

Funding/Source of Contributions:
Employee Contributions

Type of Plan: Health Care Contribution/Flexible Spending Account 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

Legal process also can be served on the plan administrator.

For information about the procedure for a QMCSO, please contact the HR Service Center.

Administrative Power and Responsibilities

Chevron Corporation has the discretionary authority to control and manage the administration and operation of the Health Care Spending Account. 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.

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 Chevron's 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 Spending Account Plan, 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 plans 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 plan is incorrect, you should notify the claims 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 plan administrator or the claims 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 elsewhere for the benefit of you and/or your dependent) in excess of the amount properly payable under the plan. Upon any overpayment, the plan 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 plan's constructive trustee.

If you have cause to reasonably believe that an overpayment may have been made, you 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 plan with respect to you and/or your 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.

Plan Year

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

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).

Future of the Plans

Chevron Corporation has the right to change or terminate a plan or program, including this plan, at any time and for any reason.

Recovery of Overpayments

An "overpayment" is any payment made to you and/or your covered dependent (or elsewhere for the benefit of you and/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 and/or your covered dependent has cause to reasonably believe that an overpayment may have been made, you and/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 and/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.

HIPAA

The Health Care Spending Account Plan will use protected health information (PHI) as permitted or required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A copy of the Plan's **Notice of Privacy Practices** can be obtained from the **Legal Notices** section at **hr2.chevron.com**.

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 **COBRA and Continuation Coverage** chapter 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. Additionally, you can mail your request to the HR Service Center

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** heading 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 and/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**.
- Logging on to the Internet at **www.dol.gov/ebsa/publications/main.html.**

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 under Section 502(a) of ERISA to recover a benefit under the 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 appeal has been denied).

If you don't receive a timely written denial of the claim, the plan administrator reserves the right to contend that you may still not file a legal action until you file a timely written request for a review of the denied claim with the appropriate claims administrator and that review is complete. 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 94583-2324

You also can serve process on the plan by serving the plan administrator or the plan trustee, if any, at the addresses shown in the **Administrative Information** section in the **Other Plan Information** chapter of this summary plan description. The plan administrator is the appropriate party to sue for all Chevron benefit plans.

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.

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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 medical plan coverage, prescription drug coverage, 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 **Eligibility** chapter, **Eligible Children** and **Other Dependents** sections 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.

Chevron Must Give Notice of Some Events

Chevron has the responsibility to notify the COBRA coverage administrator – currently, BenefitConnect | COBRA – 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 **Eligibility** chapter, **Eligible Children** and **Other Dependents** sections 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. Additionally, you can mail your notice to the HR Service Center.

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 open enrollment period, if applicable.

Electing Continuation Coverage

When the COBRA administrator is notified that one of these events has occurred, the COBRA administrator 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 the COBRA administrator 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 and the COBRA administrator. You should also keep a copy, for your records, of any notices you send to the HR Service Center and the COBRA administrator.

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.

how to pay for continuation coverage

You or your dependents must pay Chevron for this coverage as long as it's in effect.

First Payment

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, or the date you completed your online enrollment. Your first COBRA payment covers the period before you make your election, retroactive to your COBRA start date. 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. Health claims will not be processed and paid until you have elected COBRA and made the first payment in full.

Ongoing Payments

After the first payment, payments are due the first day of each month. For example, payment for March coverage is due March 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.

Payment Methods

COBRA premiums may be paid by one-time ACH payment, check, cashier's check, or money order. Once you have made your first payment and your COBRA coverage has been activated, you may enroll in Auto Pay. Auto Pay is not available for your first payment.

- To make payments by **one-time ACH payment**, go to the **BenefitConnect | COBRA** website or call the COBRA administrator.
- To **mail a payment**, use the payment address included in your COBRA enrollment materials or on your payment coupons. You can also call the COBRA administrator for the address.
- Instructions for enrolling in **Auto Pay** will be provided when your coverage is activated. You can also call the COBRA administrator for additional information.

Grace Period

Monthly payments are due on the first of each month with a 30-day grace period.

- For example, payment for March coverage is due March 1. If payment in full is not received by March 1, you have 30 days – until March 31 – to make payment in full.

The grace period does not apply to your first payment. Your first payment is due 45 days from your enrollment.

If you do not make payment by the first of the month, your coverage under the plan(s) may be suspended as of the first day of the month. Coverage will be retroactively reinstated (going back to the first day of the month) if the monthly payment is made before the end of the grace period. Any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted after your coverage is reinstated.

If you do not pay your full premium by the end of the grace period, your coverage will be cancelled as of the last day for which timely premium was received. Your coverage will not be reinstated, even if you subsequently pay the outstanding balance.

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. If all of the following requirements are met, 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):

- 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** chapter.

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).

important considerations when you leave chevron

Retirement from Chevron is an important enrollment milestone for retiree health benefits.

If you qualify as an eligible retiree at the time of your termination of employment with Chevron, you will have these options for you and your enrolled, eligible dependents:

- Elect to temporarily continue the employee health benefits for which you (and your eligible dependents) are enrolled through **COBRA continuation coverage,** as described earlier in this chapter. Note that you and your eligible dependents cannot simultaneously participate in both COBRA and Chevron retiree health benefits.
- Elect **Chevron retiree health coverage and/or the Retiree HRA Plan** (as applicable).
- **Waive both Chevron retiree health coverage and Chevron COBRA coverage**.

Although you have these three options at this milestone, there are several important considerations to evaluate before you make a decision. In addition there are important deadlines to meet. Please see the **Eligibility** chapter, **Enrollment Milestones** section and the **COBRA** chapter of the retiree health benefit summary plan descriptions for more information about this enrollment milestone.

- **For pre-65 retiree health benefits**, see the **Chevron Pre-65 Retiree Health Benefits** summary plan description on **hr2.chevron.com.**
- **For post-65 retiree health benefits**, see the **Chevron Post-65 Retiree Health Benefits** summary plan description on **hr2.chevron.com.**

Thinking about retirement?

Go to the **Leaving Chevron** section on **hr2.chevron.com** for important information about retirement, how it affects your Chevron benefits, how to preview your benefits, enrollment instructions and deadlines.

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.

glossary

Before-Tax Contributions
Before-tax contributions are withheld from your pay first, before certain taxes are calculated and deducted. So you pay less in taxes. Before-tax contributions aren't subject to federal income taxes — or to state income taxes in states other than New Jersey and Pennsylvania. Also (unlike before-tax contributions to 401(k) savings plans), before-tax contributions to health care plans and flexible spending account plans aren't subject to Social Security taxes.

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.

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.

Common-Law Employee
A worker who meets the requirements for employment status with Chevron under applicable laws.

Corporation
Refers to Chevron Corporation.

Eligible Dependent
See the **Eligibility** chapter of this summary plan description for the definition of an eligible dependent.

Eligible Employee
See the **Eligibility** chapter of this summary plan description for the definition of an eligible employee.

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.

Open Enrollment
Typically, open enrollment is held 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.

Payroll
The system used by Chevron to withhold employment taxes and pay those it classifies as its common-law employees. The term doesn't include any system to pay workers whom Chevron doesn't consider to be its common-law employees and for whom employment taxes aren't withheld — for example, it doesn't include workers that Chevron regards as independent contractors or common-law employees of independent contractors — even if they should be deemed to be its common-law employees.

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.

Regular Work Schedule
A continually recurring pattern of scheduled work that's established and changed by Chevron as necessary to meet operating needs.

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.

Spouse
A person to whom you are legally married under the laws of a state or other jurisdiction where the marriage took place.

Wellness Credit
Wellness Credits may be provided when an eligible employee has met conditions established by the Corporation prior to the beginning of the Plan Year, including but not limited to, the milestones of a wellness program. A Wellness Credit is an employer credit to the Chevron Health Care Spending Account (HCSA) plan. With respect to a participant in the Chevron High Deductible Health Plan (HDHP) or Chevron High Deductible Health Plan Basic (HDHP Basic), Wellness Credits shall be contributed to the Limited Purpose Health Care Spending Account.