global choice plan (U.S.-payroll expatriates)

summary plan description (SPD)
effective january 1, 2017

This summary plan description (SPD) describes the Global Choice Plan (U.S.-Payroll Expatriates) as of January 1, 2017 sponsored by Chevron that is available to eligible U.S.-payroll expatriates and their eligible dependents.

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

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

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

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

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

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

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

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

prescription drug program

effective january 15, 2022

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

The enclosed information serves as an official summary of material modification (SMM) for the plans referenced herein. Please keep this information with your other plan documents for future reference. You can access the summary plan descriptions for your benefits at **hr2.chevron.com** or by calling the HR Service Center at **1-888-825-5247** (1-832-854-5800 outside the U.S.).

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

When you enroll in the Global Choice Plan (U.S.-payroll Expatriates) or the Global Choice Plan (Expatriates in the U.S.), you are also automatically enrolled in the Prescription Drug Program with Express Scripts. This change only applies to the Prescription Drug Program for prescription drugs obtained inside the U.S. Contact Cigna directly if you have questions about similar coverage that may apply to your Cigna medical and prescription drug (obtained outside the U.S.) coverage.

The Prescription Drug Program has been amended as required by the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). **Effective January 15, 2022, each enrolled participant in the Prescription Drug Program can receive coverage for up to eight over-the-counter, at-home COVID-19 diagnostic tests every 30 days.**

overview

If you're enrolled in the Global Choice Plan (U.S.-payroll Expatriates) or the Global Choice Plan (Expatriates in the U.S.), your **medical coverage and prescription drug coverage (obtained outside the U.S.)** through Cigna already provides coverage for COVID-19 diagnostic testing.

Effective January 15, 2022, your Prescription Drug Program with Express Scripts provides coverage for covered at-home COVID-19 diagnostic tests purchased inside the U.S. You can also now obtain tests online via Express Scripts© Pharmacy or at the pharmacy counter at an Express Scripts network pharmacy. This communication describes the rules and requirements for this coverage.

- This temporary plan rule for at-home COVID-19 diagnostic tests purchased inside the U.S. will expire at the end of the **COVID-19 emergency period**. As of the date of this publication, the emergency period ends April 15, 2022, but is subject to change.
- **This temporary plan rule only applies to covered at-home COVID-19 diagnostic tests that have *not* been prescribed by, ordered by, or obtained with the involvement of a health care provider or physician.** COVID-19 diagnostic testing that has been physician-ordered and/or administered by a health care provider or a health care facility continues to be covered by your medical coverage with Cigna under the Global Choice Plan. Contact Cigna directly if you have questions about this coverage.
- **This temporary plan rule only applies to covered at-home COVID-19 diagnostic tests that have been purchased inside the U.S.** COVID-19 diagnostic testing that has been purchased outside the U.S. continues to be covered by your medical coverage with Cigna under the Global Choice Plan. Contact Cigna directly if you have questions about this coverage.
- As is true with *all* reimbursements under the plan, the Prescription Drug Program cannot be used to reimburse covered at-home COVID-19 diagnostic tests that have already been reimbursed or paid under any other benefit plan or arrangement, such as your Cigna medical or prescription drug coverage, a health flexible spending account plan, a health savings account, or a spouse's or dependent's health plan.
- The plan coverage described here applies to individualized diagnostic testing for COVID-19 and *not* for any other purpose including, but not limited to, public health surveillance or employment purposes (such as screening for general workplace health and safety).

covered testing products

- Covered at-home COVID-19 diagnostic tests must be purchased on or after **January 15, 2022**, to be eligible for reimbursement.
- To receive reimbursement, the test(s) must be on the **list of covered at-home COVID-19 diagnostic testing products**. Express Scripts, the claims administrator for the Chevron Prescription Drug Program, will maintain this list. Contact Express Scripts directly at **1-800-987-8368** if you have questions about products that are covered.
- You *do not* need a prescription for reimbursement of covered at-home COVID-19 diagnostic tests.

List of Covered At-Home COVID-19 Diagnostic Testing Products
As of the date of this publication, the products currently covered are included below. Please note this list is not inclusive and will change periodically as updates occur. Contact Express Scripts directly at **1-800-987-8368** for a more current list or if you have questions about products that are covered.

COVID-19 AT-HOME TEST	IHEALTH COVID-19 AG HOME TEST
INTELISWAB COVID-19 HOME TEST	ELLUME COVID-19 HOME TEST
BINAXNOW COVID-19 AG SELF TEST	ON-GO COVID-19 AG AT HOME TEST
QUICKVUE AT-HOME COVID-19 TEST	FLOWFLEX COVID-19 AG HOME TEST

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quantity and time limits for coverage

Coverage for at-home COVID-19 diagnostic tests under the Prescription Drug Program is subject to a quantity and time limit, as included below. Quantity and time limits that may apply under your Cigna medical and prescription drug coverage is tracked separately by Cigna; contact Cigna directly if you have questions.

- **Each enrolled participant** is eligible to receive coverage for **up to eight** covered tests **every 30 days**. Tests purchased that exceed this quantity and time limit are *not* reimbursable under the Prescription Drug Program.
- This requirement is measured in a **rolling 30-day period**, *not* a calendar month.
- The quantity limit applies to **individual tests**, *not* to kits. For example, if a single testing kit includes three individual tests, then three tests would be applied against your eight test limit.
- The quantity limit and the 30-day period are tracked **for each enrolled participant**, *not* for each family. For this reason, when you make a purchase or submit a claim, you'll be asked to specify for which participant the kits were purchased.
- The quantity limit and the 30-day period are tracked for each enrolled participant **regardless of where and how the tests were purchased**. For example, a participant could obtain two tests from the online Express Scripts Pharmacy, two tests from the pharmacy counter at a network pharmacy and submit a manual claim for two tests purchased from another online retailer. All six tests would be tracked toward the participant's quantity limit of eight tests every 30 days.

Keep in mind that while your benefits provide coverage for up to eight tests, your retailer or pharmacy may impose separate purchase limits on at-home COVID-19 diagnostic tests.

do you have a health account?

If your at-home COVID-19 diagnostic test *isn't* reimbursable under the Chevron Prescription Drug Program with Express Scripts or through your Cigna coverage, your Health Care Spending Account (HCSA) or a health savings account (HSA) may be a good reimbursement alternative. Just remember the HCSA or an HSA cannot be used to reimburse eligible expenses that have *already* been reimbursed or paid under any other benefit plan or arrangement, such as your Chevron medical or prescription drug coverage, or a spouse's or dependent's health plan.

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what the program pays

As a reminder, each enrolled participant is eligible to receive up to eight covered tests every 30 days. Tests purchased that exceed this quantity and time limit are *not* reimbursable under the Prescription Drug Program. The level of reimbursement varies depending on how and where you purchased a covered test.

online express scripts© pharmacy

When purchased **online** directly from the **Express Scripts© Pharmacy**, your at-home COVID-19 tests are **free** with no shipping, copayment/coinsurance, or deductible. Remember, as is true with the normal mail-order pharmacy, Express Scripts cannot ship orders outside the U.S. or through the Chevron mail system. The system also will not allow an order if a participant has exceeded the Prescription Drug Program's quantity and time limit. You must login to your Express Scripts account at www.express-scripts.com and choose the **Order At-Home COVID-19 Tests** link to place your order with the online pharmacy.

pharmacy counter at a retail network pharmacy in the U.S.

When purchased from the *pharmacy* counter at a retail **network pharmacy in the U.S.**, covered test kits will be paid at **100%** with **no copayment/coinsurance** and **no deductible**. You'll need to present your Express Scripts ID card at the time of service for verification of coverage. You do not need to submit a claim. *Do not use the regular checkout lane; to receive this level of coverage you must checkout at the pharmacy counter.*

If you were charged for your test and need reimbursement

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

- You purchase from an out-of-network pharmacy in the U.S.
- You purchase from another non-Express Scripts online retailer in the U.S. (For example, Amazon.com or Walmart.com.)
- You purchase from a network pharmacy in the U.S., but your prescription drug coverage cannot be verified at the time of purchase. (For example, if you forget your Express Scripts ID card or you used the regular checkout lane.)
- Any other time that prescription drug coverage for covered at-home COVID-19 diagnostic tests that were purchased inside the U.S. and could not be verified at the time of purchase; therefore, you paid the full cost out-of-pocket and submitted a manual claim for reimbursement from Express Scripts at a later date.

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how to submit a manual claim for reimbursement

If you had to pay the full cost of your at-home COVID-19 diagnostic test at the time of purchase, you'll need to submit a manual claim for reimbursement. Here's how:

online

- Log in to your **Express Scripts** account at www.express-scripts.com.
- From the **Benefits** tab on the top navigation, choose **Forms**.
- Go to the **Request Reimbursement** section to get started.
- Be sure to review the online form carefully for special instructions and tips designed to help you properly complete certain fields when making a claim for reimbursement of at-home COVID-19 diagnostic test(s).

by paper

- The Express Scripts claim form has been recently updated to include a special section for at-home COVID-19 test claims. Be sure to use the new form or your reimbursement could be delayed, or even denied.
- You can also access this form from the **Benefits** tab when you login to your **Express Scripts** account at www.express-scripts.com.

Find a network pharmacy, ask questions

- www.express-scripts.com
  Select your plan to locate a pharmacy or price a medication.
- Call **Express Scripts** at **1-800-987-8368**
- Network name: **National Plus Network**
- Chevron group number: **CT1839**

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new coverage for weight loss class of prescription drugs

chevron prescription drug program
effective january 1, 2022

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

The enclosed information serves as an official summary of material modification (SMM) for the **Prescription Drug Program** for participants in the **Chevron Medical PPO Plan,** the **High Deductible Health Plan (HDHP)** the **High Deductible Health Plan Basic (HDHP Basic)** and the **Global Choice Plan**. Please keep this information with your other plan documents for future reference. You can access the summary plan descriptions for your benefits at **hr2.chevron.com** (or **hr2.chevron.com/retiree**) or by calling the HR Service Center at **1-888-825-5247**.

new coverage for weight loss class of prescription drugs

Effective **January 1, 2022**, the weight loss class (anorexiants and appetite suppressants) of prescription drugs will now be covered by the Prescription Drug Program as follows:

- All generic equivalents will be covered, while only certain brand-names, such as Wegovy and Saxenda, will be covered. Refer to the 2022 Prescription Drug Program Formulary for covered drugs.
- Prior authorization will apply – whether generic or brand-name is prescribed.

Your Prescription Drug Program standard **deductible**, **coinsurance** or **copayment**, **out-of-pocket maximum** and **maintenance drug refill** rules and requirements will apply. The Prescription Drug Program's standard schedule of benefits for **Preferred Brand-Name Drugs** or **Non-Preferred Brand-Name Drugs** will apply to covered weight loss drugs.

As a reminder, when you enroll in the Medical PPO Plan, the High Deductible Health Plan (HDHP), the High Deductible Health Plan Basic (HDHP Basic), or the Global Choice Plan you are also automatically enrolled in prescription drug coverage through the **Chevron Prescription Drug Program** with Express Scripts. For expatriates in the Global Choice Plan, the Prescription Drug Program with Express Scripts only applies to mail order or prescription drugs obtained inside the U.S.

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who to contact

- If you currently use one of these covered drugs and have questions about this new coverage, contact **Express Scripts Member Services** at **1-800-987-8368** starting October 18, 2021.

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.

your rights and protections against surprise medical bills

no surprises act

effective january 1, 2022

Update to the summary plan description (SPD)
All changes described in this SMM are effective January 1, 2022.

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legislation that affects your benefits

This document provides information about the *Surprise Billing* provision of the No Surprises Act, a consumer protection law that helps curb the practice known as surprise billing for medical care. This information is provided for your awareness only; your action is not required.

This legislation applies to all covered participants in all Chevron-sponsored medical, prescription drug, mental health and substance use disorder plans. If you have questions about this information, contact your health plan directly for assistance.

your rights and protections against surprise medical bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is *balance billing* (sometimes called *surprise billing*)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

Out-of-network describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called *balance billing*. This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

Surprise billing is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you think you've been wrongly billed, you can contact the Employee Benefits Security Administration (EBSA), the No Surprise Help Desk (NSHD) at 1-800-985-3059 or https://www.cms.gov/nosurprises/consumers, or your State Regulator, if your plan is fully insured, to ask whether the charges are allowed by law.

your right to receive continuation of care

no surprises act

effective january 1, 2022

Update to the summary plan description (SPD)
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legislation that affects your benefits

This document provides information about the *Continuity of Care* provision of the No Surprises Act, a consumer protection law that applies when a provider ceases to be a network provider during an ongoing course of treatment. This information is provided for your awareness only; your action is not required.

This legislation applies to all covered participants in all Chevron-sponsored medical, prescription drug, mental health and substance use disorder plans. If you have questions about this information, contact your health plan directly for assistance.

In general, under the No Surprises Act, if your provider or facility leaves your health plan's network, coverage for continued transitional care from that provider or facility at the network level of benefits may be available to you for up to 90 days. As a consumer, you should know that:

- You must satisfy certain defined conditions to be eligible for continuity of care. Continuity of Care generally, applies to hospitalization, a course of institutional care, scheduled to undergo nonelective surgery, pregnancy, and treatment for a serious and complex condition.
- Your health plan claims administrator is required to timely notify continuing care patients of network terminations affecting your provider or facility and your right to elect continued transitional care from your provider or facility.
- Continuation of care is not automatic. You will generally be required to apply for this transition care by following your health plan claims administrator's application process.

If you want to learn more about Continuation of Care, including eligibility requirements or how to apply, contact your health plan's claims administrator directly.

rare conditions program
prescription drug program
effective january 1, 2021

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Update to the summary plan description (SPD)
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new rare conditions program

This change applies to the Prescription Drug Program for prescription drugs obtained inside the U.S. for participants in the Global Choice Plan (Expatriates in the U.S.) and the Global Choice Plan (U.S.-Payroll Expatriates).

When you enroll in the Global Choice Plan (Expatriates in the U.S.) or the Global Choice Plan (U.S.-Payroll Expatriates), you are also automatically enrolled in prescription drug coverage through the Prescription Drug Program with Express Scripts.

The Prescription Drug Program currently has condition-specific specialty programs in place which include access to specialist pharmacists, nurses and other clinicians who are trained for your specific condition. There are programs are already in place for conditions such as hepatitis, diabetes, cancer, and more. **Effective January 1, 2021 a new condition-specific specialty program – the Rare Conditions Care Value Program® – will be added to your Express Scripts prescription drug coverage.**

Rare Conditions Care Value Program®

The Rare Conditions Care Value Program® manages rare conditions and tailors patient care through a combination of formulary, utilization management and specialized support including monitoring and on-going patient assessments. Conditions such as Acromegaly, Alpha-1 Deficiency, Gaucher's Disease, Hemophilia, Hereditary Angioedema, Huntington's disease and Idiopathic Pulmonary Fibrosis are currently included in the Rare Conditions Care Value Program® .

These changes provide additional services; they don't affect your current prescription drug benefit. You'll be notified by Express Scripts during 2021 if your condition and medication is subject to this program and advised what you need to do, if anything. Starting October 19, 2020 contact Express Scripts Member Services at 1-800-987-8368 for more information about the Rare Conditions Care Value Program® .

continuous glucose monitoring systems
prescription drug program
effective january 1, 2021

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Update to the summary plan description (SPD)
All changes described in this SMM are effective January 1, 2021.

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new coverage for continuous glucose monitoring systems

This change applies to the Prescription Drug Program for prescription drugs obtained inside the U.S. for participants in the Global Choice Plan (Expatriates in the U.S.) and the Global Choice Plan (U.S.-Payroll Expatriates).

When you enroll in the Global Choice Plan (Expatriates in the U.S.) or the Global Choice Plan (U.S.-Payroll Expatriates), you are also automatically enrolled in prescription drug coverage through the Prescription Drug Program with Express Scripts.

Effective **January 1, 2021**, sensors *and* transmitters used with continuous glucose monitoring systems will be covered by the Prescription Drug Program.

- This coverage does *not* include the display/receiver device. For example, many monitoring systems use a smartphone as a receiver, so the smartphone is not covered.
- Common continuous glucose monitoring systems include the Dexcom, Freestyle Libre, Eversense, Guardian and Enlite systems.

Your Prescription Drug Program standard **deductible**, **coinsurance** or **copayment**, and **out-of-pocket maximum** rules and requirements will apply. The Prescription Drug Program's standard schedule of benefits for **Preferred Brand-Name Drugs** or **Non-Preferred Brand-Name Drugs** will apply to covered continuous glucose monitoring systems.

If you use one of these devices and have questions about this new coverage, contact **Express Scripts Member Services** at **1-800-987-8368** starting **October 19, 2020**.

coverage for immunizations, including the COVID-19 vaccine

prescription drug program

effective february 15, 2021

Update to the summary plan description (SPD)
All changes described in this SMM are effective February 15, 2021.

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

coverage for immunizations, including the COVID-19 vaccine

When you enroll in the Chevron Global Choice Plan, you are also automatically enrolled in the Chevron Prescription Drug Program (with Express Scripts) for prescription drugs obtained inside the U.S. This change applies to the Prescription Drug Program for participants in the Global Choice Plan (U.S.-payroll Expatriates) and the Global Choice Plan (Expatriates in the U.S.). For questions about coverage for immunizations, including the COVID-19 vaccine, obtained outside the U.S., contact Cigna directly.

Effective **February 15, 2021**, the Prescription Drug Program will provide coverage for certain immunizations for enrolled participants as follows:

- Covered immunizations *can* be received from a **U.S network pharmacy** or a **U.S out-of-network pharmacy**. When you visit an Express Scripts network pharmacy, you'll need to present your Express Scripts ID card at the time of service.
- To be covered, the immunization must be on the **Express Scripts Standard Preventive Drug List** and/or qualifies as **preventive care** under the Affordable Care Act. Influenza and COVID-19 vaccines are examples of covered immunizations. Contact Express Scripts directly if you have specific questions about covered immunizations.
- Covered immunizations will be paid at **100%** with **no copayment/coinsurance** and **no deductible**. If you visit a U.S. out-of-network pharmacy, you'll have to pay the pharmacy at the time of service, then submit a claim to Express Scripts for reimbursement.
- The immunization must be clinically appropriate and legally acceptable to be administered in a pharmacy setting. For this reason, not all covered immunizations will be available from a pharmacy, and availability may vary from state-to-state due to local laws.

Immunizations for travel outside the United States or for occupational requirements are not covered under the Prescription Drug Program, regardless of whether those immunizations are received from a pharmacy, network, or out-of-network. Contact your Chevron Global Mobility Specialist or the Global Health and Medical team for questions about necessary immunizations related to expatriate assignments.

Participants enrolled in the Global Choice Plan, will also continue to have coverage for immunizations as part of the Affordable Care Act preventive care coverage under the **medical benefit** portion of your health plan with Cigna. Contact Cigna directly if you have questions about your medical coverage.

Find a network pharmacy, ask questions

If you plan to get an immunization at a U.S. pharmacy, search the Express Scripts provider network and review the current formulary to ensure your immunization is covered.

- **www.express-scripts.com/chevron**
  Select your plan to locate a pharmacy or price a medication.
- You can also **call Express Scripts at 1-800-987-8368**

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legal guardian clarification
effective january 1, 2021

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legal guardian clarification

This clarification applies to the Omnibus Health Care Plan of Chevron Corporation, including any of its supplement health care plans[1].

If you enroll for coverage under a Chevron health plan, you also may enroll your eligible dependents for coverage under the same plan. The definition for an **eligible child** includes the ability to enroll an **"other dependent"** for coverage if he or she meets certain eligibility criteria.

The following eligibility criteria for an "other dependent" has been restated to reflect how this requirement is administered when determining a dependent's eligibility for health coverage. As this update is only a clarification, there is no current effect on your coverage.

- **Previous statement:** Someone for whom you act as a guardian.
- **New statement:** Someone for whom you act as a legal guardian.

[1] Omnibus Health Care Plan of Chevron Corporation and its supplement health care plans encompasses the following U.S. health benefit plans:

- Medical PPO Plan
- High Deductible Health Plan (HDHP)
- High Deductible Health Plan Basic (HDHP Basic)
- Global Choice Plan (U.S. Payroll Expatriates)
- Global Choice Plan (Expatriates in the U.S.)
- Medical HMO Plans
- Dental HMO Plans
- Mental Health and Substance Use Disorder Plan
- Dental PPO Plan
- Prescription Drug Program
- Vision Plus Program
- Health Decision Support Program

coverage for influenza vaccine
prescription drug program
effective september 15, 2020 – december 31, 2020

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Update to the summary plan description (SPD)

All changes described in this SMM are effective September 15, 2020 through December 31, 2020.

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

coverage for influenza vaccine

When you enroll in the Global Choice Plan (U.S.-payroll Expatriates) or the Global Choice Plan (Expatriates in the U.S.), you are also automatically enrolled in prescription drug coverage through the Prescription Drug Program. Express Scripts administers your prescription drugs for prescriptions obtained in the United States or by mail-order within the United States. This change applies to the Prescription Drug Program for participants in the Global Choice Plan (U.S.-payroll Expatriates) and the Global Choice Plan (Expatriates in the U.S.).

Effective **September 15, 2020** through **December 31, 2020**, the Prescription Drug Program will provide coverage for influenza vaccines for enrolled participants as follows:

- The influenza vaccine must be received from an **Express Scripts network pharmacy in the U.S.** You'll need to present your Express Scripts ID card at the time of service.
- The influenza vaccine administered must be on the **Express Scripts National Preferred Formulary** and can be delivered in either the injectable or intranasal form.
- Covered influenza vaccines will be paid at **100% of the Network Price** with no copayment/coinsurance and no deductible.

Participants enrolled in the Global Choice Plan (U.S.-payroll Expatriates) and the Global Choice Plan (Expatriates in the U.S.) will also continue to have coverage for the flu shot as part of the standard preventive care coverage under the medical benefit.

It's important to understand that the Prescription Drug Program doesn't provide coverage for influenza vaccines that are *not* on the Express Scripts National Preferred Formulary or if the vaccine is received from an out-of-network pharmacy or a pharmacy outside the U.S. If you plan to get your flu shot at a pharmacy, go to **hr2.chevron/flushot** to search the Express Scripts provider network or to review the current formulary. You can also call Express Scripts Member Services at 1-800-987-8368 for assistance.

prescription drug program
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 unless otherwise indicated.

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

managed prior authorization for xyrem

This change applies to the Prescription Drug Program for prescription drugs obtained inside the U.S. for participants in the Global Choice Plan (Expatriates in the U.S.) and the Global Choice Plan (U.S.-Payroll Expatriates).

When you enroll in the Global Choice Plan (Expatriates in the U.S.) or the Global Choice Plan (U.S.-Payroll Expatriates), you are also automatically enrolled in prescription drug coverage through the Prescription Drug Program with Express Scripts.

Effective January 1, 2020, the specialty narcolepsy drug – Xyrem – will be subject to prior authorization under the Prescription Drug Program.

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

You'll be notified by Express Scripts if your medication is subject to prior authorization during 2020, including what you need to do, if anything. Starting **October 14, 2019**, contact Express Scripts Member Services at **1-800-987-8368** if you have questions about prior authorization as it pertains to your personal situation.

medical coverage for expatriate assignments

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 the plans referenced herein. Please keep this information with your other plan documents for future reference. You can access the summary plan descriptions for your benefits at **hr2.chevron.com / hr2.chevron.com/retiree** or by calling the HR Service Center at **1-888-825-5247**.

Medical Coverage for Expatriate Assignments

Effective January 1, 2019, coverage rules for U.S.-payroll employees going on a temporary or resident expatriate assignment for greater than 6 months are as follows:

- Eligible employees not enrolled in Chevron medical coverage immediately prior to starting the expatriate assignment will be automatically enrolled for medical coverage in the **Chevron Global Choice Plan (U.S.-Payroll Expatriates)** on the effective date of your expatriate assignment. The Global Choice Plan is the only medical plan option available while on this type of assignment.
- You will have 31 days from the effective date of your expatriate assignment to add eligible dependents to your Global Choice Plan coverage.

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.

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.

after-tax contributions eliminated

medical 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** or by calling the HR Service Center at **1-888-825-5247**.

employee after-tax contributions eliminated

Under current plan rules, you have the choice to pay the monthly premiums for certain health and welfare coverage through either before-tax or after-tax payroll deductions while you're an active employee. As part of our recent transition to a new benefits administrator for the HR Service Center, we have changed some of our current administrative processes and plan rules to align with the standards of our new administrator. For this reason, effective January 1, 2019, premiums for the health and welfare plans listed below can only be made through before-tax payroll deductions while you're an active employee:

- 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).

If you're currently paying for this coverage on an after-tax basis, your coverage will be automatically changed to a before-tax basis effective January 1, 2019. If you're already paying for coverage on a before-tax basis, this change won't affect you.

Most employees already pay for coverage on a before-tax basis, but if you're not sure, you can check your current tax basis for these plans by viewing your paycheck advice online.

dependent verification requirement health plans

effective january 1, 2019

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All changes described in this SMM are effective January 1, 2019 unless otherwise indicated.

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dependent verification process

During 2019 open enrollment, you will be required to verify the eligibility of any **new** dependents you intend to enroll in your Chevron health plans.

At this time, this dependent verification process only applies to new dependents that have not been covered under your Chevron health plans within the last two years. You are not currently required to provide documentation to continue enrollment for eligible dependents that are currently covered under your Chevron health plans. You should review the definition for eligible spouses, domestic partners, and children on **hr2.chevron.com/openenrollment**.

Step one: Enroll your new dependent

- Go to **hr2.chevron.com/openenrollment** and access **BenefitConnect** to make open enrollment elections. You can also make elections by phone (see Page 8).
- If you add a new dependent to your health coverage, you'll be prompted to select their eligibility status to complete enrollment.
- Complete your enrollment elections and checkout. Click to review and print a confirmation of elections.

Step two: Provide documentation

- Click the **Needs Verification** message on your confirmation or your system alerts. Follow the on-screen instructions to **upload electronic documents or send copies** by mail or fax to the HR Service Center.
- If you don't have the documents when you enroll, don't worry. You can go back later to complete the verification request. You have **up to 60 days** to obtain and submit the documentation. You can preview a list of acceptable documents to verify eligibility for each type of dependent on **hr2.chevron.com/openenrollment**.
- The documentation you submit must be executed in the English language. If your documentation is in another language, it's your responsibility to obtain a **notarized translation** of the documentation, at your personal expense. When you submit the documentation, you must include a copy of the original document along with a copy of the notarized translation of that document. The 60-day deadline also applies to documentation requiring a notarized translation.

Step three: Watch for notifications

After you submit your documentation, a statement confirming your dependent's eligibility to participate will be sent to you.

- If additional information is required, you'll be notified.
- If your dependent is **not eligible** to participate, the dependent will be disenrolled from the plan at the end of the month in which you receive notification.
- If the **60-day deadline to submit the documentation expires** and the HR Service Center has received no documentation or insufficient documentation, then the dependent will be disenrolled from the plan at the end of the month in which the 60-day deadline occurs.

prescription drug program
advanced opioid management program
effective january 1, 2019

human energy. yours.™

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 the plans referenced herein. Please keep this information with your other plan documents for future reference. You can access the summary plan descriptions for your benefits at **hr2.chevron.com** or by calling the HR Service Center at **1-888-825-5247**.

The enclosed plan changes apply to the **Global Choice Plan (U.S.-Payroll Expatriates)** for prescription drugs obtained inside the U.S. or through mail order in the U.S.

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.

prescription drug program

advanced opioid management program

The opioid epidemic has become a major focus in the United States as opioid use, associated hospitalizations and deaths are higher than anywhere else in the world. Millions of people are prescribed opioids because they're an effective treatment for pain when taken correctly. But because they can be addictive, it's important to use them as prescribed and take extra precautions when storing and disposing of them. That's why Express Scripts' **Advanced Opioid Management Program** will be implemented for Chevron's Prescription Drug Program effective January 1, 2019.

If you are enrolled in the **Medical PPO Plan**, the **High Deductible Health Plan (HDHP)**, or the **High Deductible Health Plan Basic (HDHP Basic)**, you automatically have prescription drug coverage through the Prescription Drug Program administered by Express Scripts. Your current coverage already includes controls to manage opioid use, but the Advanced Opioid Management Program will add additional components that target other opioid safety strategies now being used across the nation. The Advanced Opioid Management Program includes:

- **Quantity limits and preauthorization requirements.** These practices not only reduce the risk of addiction and overdose in the patient, but also the likelihood that excess doses are being obtained and misused by others.
- **Proactive participant education and consultation.** An educational letter from Express Scripts and individual consultations with an Express Scripts specialist pharmacist will help to ensure you understand potential risks and safe use of these drugs. The pharmacist will also cover the other critical responsibilities for opioid use, including safe storage while you're using them, and proper disposal when you're done.
- **Physician alerts and communication.** Express Scripts will provide physicians with alerts and information to help ensure compliance with recommended guidelines for opioid prescribing and prevention of overuse. These communications will also notify physicians of circumstances where certain patients may be visiting other physicians or pharmacies to obtain opioid prescriptions.
- **Enhanced fraud, waste, and abuse monitoring.** This monitoring will be expanded from the current standard level for network pharmacies to include continuous monitoring of member opioid use and physician prescribing patterns. The focus of the enhanced monitoring is to identify situations of abnormal use, abnormal prescribing or other high-risk scenarios. Express Scripts will use a special investigations unit to further examine patterns, when necessary.

have questions?

If you have questions about the Advanced Opioid Management Program, call **Express Scripts Member Services** at **1-800-987-8368**.

what this means when you are prescribed an opioid medication

Starting January 1, 2019, if you're prescribed, and subsequently fill, a prescription for an opioid medication, your medication will be subject to the following rules. It's important to know that the rules listed below are typically bypassed if a member has a history of cancer or palliative care.

quantity limits

✓ Prevention of patient overuse	**Morphine Equivalent Dose (MED) based quantity limit** Not all opioids are the same. This cumulative quantity level limit tracks the Morphine Equivalent Dose (MED) for each opioid dispensed. The MED is a calculation that applies a conversion factor to the pain relief value of your opioid medication and the comparable pain relief provided by morphine. There are pre-defined MED thresholds; if exceeded, your prescription will require additional review and authorization.
✓ Prevention of excess medications	**Short Acting Opioid – First Fill** A days' supply limit is placed on the first fill of a short acting opioid for new opioid users.
✓ Prevention of patient overuse	**Fentanyl Patches** Fentanyl products are generally only approved for treatment of chronic pain and are considered long-acting opioids. The dosing guidelines on fentanyl patches indicate transdermal patches for use every 72 hours. Therefore, Express Scripts' quantity limit on fentanyl patches is now a "per day" quantity limit of: • 15 patches for 30 days at retail. • 45 patches for 90 days at mail.

prior authorization

✓ Patient safety measure	**Long Acting Opioid** Prior Authorization is required on all long-acting opioids if the member has not had a prior fill for an opioid.
✓ Patient safety measure	**Transmucosal Immediate Release Fentanyl (TIRF) products** TIRF products are approved only for treatment of breakthrough cancer pain. To support FDA guidelines, prior authorization is required on these products to ensure an additional prescriber evaluation is completed prior to dispensing. Prescribers issuing prescriptions for TIRF products will be expected to supply supporting documentation confirming the medical necessity of these medications.

prescription drug program
condition-specific prescription drug programs

diabetes, oncology, inflammatory conditions, multiple sclerosis, pulmonary conditions

effective january 1, 2018

human energy. yours.™

Update to the summary plan descriptions (SPD)
All changes described in this SMM are effective January 1, 2018 unless otherwise indicated.

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

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 condition-specific prescription drug programs

diabetes, oncology, inflammatory conditions, multiple sclerosis, and pulmonary conditions

If you are enrolled in the Medical PPO Plan, the High Deductible Health Plan (HDHP) or the High Deductible Health Plan Basic (HDHP Basic), you automatically have prescription drug coverage through the Prescription Drug Program with Express Scripts. The Prescription Drug Program currently has specialty drug and specialty pharmacy requirements in place, including access to specialist pharmacists, nurses and other clinicians who are trained to your specific condition.

Effective January 1, 2018, a variety of specialized services and support tools will be available. These programs are already in place for hepatitis and cholesterol care, but Express Scripts will expand these programs to now include:

- Diabetes Care Value Program℠
- Oncology Care Value Program®
- Inflammatory Conditions Care Value Program℠
- Multiple Sclerosis Care Value Program℠

The end goal of these programs is to help you stay on your medication regime for the long-term. Studies show that adhering to proper and consistent medication therapies can help you avoid hospital visits or a recurrence of dangerous symptoms and complications.

These changes provide additional access to services; they don't affect your current prescription drug benefit. You'll be notified by Express Scripts if your condition and medication is subject to any of these programs during 2018, including what you need to do, if anything. Starting October 16, 2017, to find out if your prescription drug is subject to the specialty drug program and these condition-specific services, contact Express Scripts Member Services at 1-800-987-8368.

First fill at Accredo, the Express Script Specialty Pharmacy

As a reminder, if you are prescribed certain specialty drugs to treat conditions like the ones above, you may be required to have them dispensed from the Express Scripts Specialty Pharmacy – Accredo – starting with the **first fil**l. This is not a change from current practice; this specialty pharmacy and the fill requirement is already part of your prescription drug benefit. The affected medications will not be covered if supplied by your doctor or another pharmacy. You will receive refill reminders and they will schedule and quickly ship all your specialty medications, including those that require special handling, such as refrigeration. You'll be notified by Express Scripts if your condition and medication is subject to this requirement. You can also call Express Scripts Member Services at 1-800-987-8368 for information.

pay your 90-day supply in 30-day installments

Express Scripts will allow you to opt to pay for your 90-day supply in three installments using only your credit card, bank debit card, Health Care Spending Account (HCSA) card, or health savings account (HSA) card. By using the Extended Payment Program you can get a long-term supply of your medication but continue to pay for that prescription as though you're filling a short-term supply. It's a cost-effective way to adhere to your therapy long-term. There is no minimum dollar amount required for participation and there is no service fee. You can sign up for the Extended Payment Program either by speaking with Express Scripts Member Services at 1-800-987-8368 or through the payment options available on **www.express-scripts.com**.

Pulmonary Care Value Program℠

In addition to the condition-specific programs above, Express Scripts will also introduce the Pulmonary Care Value Program℠ for Chevron participants starting January 1, 2018. This program targets pulmonary conditions including asthma and chronic obstructive pulmonary disease (COPD) with an enhanced level of care including:

- All pulmonary prescriptions will be filled through Express Scripts Home Delivery at a 90-day supply quantity level. This requirement ensures you have consistent access to your medication to promote adherence.
- Qualified members will also have voluntary access to the Mango Health app or Pulmonary Remote Monitoring via a Bluetooth enabled device. These high-tech tools will help you learn how to use your pulmonary therapy effectively and consistently.

If you are currently taking any of the affected medications, you will receive detailed information directly from Express Scripts in early December. You don't need to do anything now.

Diabetes Care Value Program℠

This program includes specialized services and support tools, similar to the other Express Scripts condition-specific programs. In addition, covered medication will be filled through Express Scripts Home Delivery up to a 90-day supply quantity level. This requirement ensures you have consistent access to your medication to promote adherence.

Therapeutic Resource Centers®

All of Express Scripts' condition-specific programs include no-cost access to Therapeutic Resource Centers® (TRC). TRCs are pharmacy practices that specialize in caring for participants with the most complicated and chronic conditions, including cardiovascular disease, diabetes, cancer, HIV, asthma, depression, and many rare and specialty conditions. You'll be able to engage directly with specialist pharmacists and nurses who can help you:

- Understand your medication and how to take it.
- Avoid dangerous medication mistakes.
- Get help saving money on your prescriptions.

You can access a TRC specialist pharmacist by calling Express Scripts Member Services at **1-800-987-8368** and requesting counseling from a specialist pharmacist. You can also send an email by logging into the Express Scripts website at **www.express-scripts.com**

table of contents

key health benefit contacts

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

- 1-888-825-5247 (inside the U.S.)
- 1-832-854-5800 (outside the U.S.)

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

- **hr2.chevron.com**

Cigna
Medical coverage (inside and outside the U.S.) and prescription drugs (obtained outside the U.S.).

- **www.cignaenvoy.com**
- **Customer Service**
  - Toll free: 1-800-441-2668
  - Direct (collect calls accepted): 001-302-797-3100
  - Toll-free facsimile number: 001-302-797-3150
- **Mail Delivery**
  Cigna
  P.O. Box 15050
  Wilmington, DE 19850-5050
- **Courier Delivery**
  Cigna
  300 Bellevue Parkway
  Wilmington, DE 19809

Express Scripts
Prescription Drug Program (obtained inside the U.S.).

- **www.Express-Scripts.com**
- 1-800-987-8368

VSP Vision Services
Basic vision coverage

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

BenefitConnect COBRA
COBRA and Continuation Coverage

- 1-877-292-6272 (Inside the U.S.)
- 1-858-314-5108 (Outside the U.S.)

who's eligible to participate

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

eligible employees

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

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

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

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

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

However, you're not eligible if any of the following applies to you:

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

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

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

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

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

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

- You're a professional intern.

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

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

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

eligible dependents

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

Eligible Spouse

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

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

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

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

Eligible Domestic Partner

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

This form is available through the HR Service Center. The original of the affidavit form must be notarized and sent to the HR Service Center. By signing the affidavit, you certify that you and your partner meet one of the following qualifications:

1. You and your partner are all of the following:
    - At least age 18 and of legal age.
    - Mentally competent to enter into contracts.
    - Jointly responsible for each other's welfare and financial obligations and have lived together for at least six months prior to signing the affidavit.
    - In an intimate, committed relationship of mutual caring that has existed for at least six months prior to the signing of the affidavit and it is expected to continue indefinitely.
    - Not related by blood.
    - Not married to anyone other than each other.

2. You live in California and meet all of the requirements of the California Family Code section 297 definition of a domestic partner, including the requirement to have registered your domestic partner with the Secretary of State's office. For more information, visit the California Domestic Partnership website at www.ss.ca.gov/business/sf/sf_dp.htm.

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

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

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

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

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

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

Eligible Children and Other Dependents

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

- You or your spouse's/domestic partner's natural child, stepchild, legally adopted child, foster child, or a child who has been placed with you or your spouse/domestic partner for adoption.
- Younger than age 26. Coverage continues until the end of the month in which your child turns age 26.

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

- Not married.
- Younger than age 26. Coverage continues until the end of the month in which your other dependent turns age 26.
- Is a member of your household.
- Someone for whom you act as a guardian.
- Dependent on you (or on your spouse/domestic partner) for more than 50 percent of his or her financial support.

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

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

For chronic disabilities, as determined by the medical administrator, you must provide documentation every two years. If the disability is not chronic, the medical administrator will determine how frequently you will need to provide such documentation. For details, contact the HR Service Center.

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

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

Before your child can be enrolled, you may be required to provide proof of his or her eligibility.

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

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

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

participation

This section provides a description of the eligibility requirements to participate in the Global Choice Plan (U.S.-Payroll Expatriates).

A Snapshot of What to Do When

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

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

Before-Tax vs. After-Tax Contributions

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

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

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

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

Congress may change the laws that govern before-tax contribution programs. Chevron will notify you if you're affected by any changes in the laws.

Imputed Income and Before-Tax vs. After-Tax Contributions for Domestic Partners

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

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

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

- You live in California and meet all of the requirements of the California Family Code section 297 definition of a domestic partner, including the requirement to have registered your domestic partner, with the Secretary of State's office. For more information, visit the California Domestic Partnership website at **www.ss.ca.gov/business/sf/sf_dp.htm**. If you reside in California, you will be exempt from imputed income if you report that your domestic partner meets the state's requirement of a tax dependent and you report that you have registered your domestic partner with the Secretary of State.
- You live in another state such as Oregon or the District of Columbia that recognizes domestic partnerships and you meet that state's requirements to cover your domestic partner on a before-tax basis. Check with your tax advisor about the tax treatment of coverage.

Before you enroll your domestic partner in Chevron benefits, request and complete the "domestic partner" package that includes important forms and personalized information about benefits enrollment, taxes and beneficiaries. Contact the HR Service Center to speak with a Customer Service representative.

Making Changes

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

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

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

Midyear Changes

If you pay for your medical coverage on a before-tax basis, because of the plan's tax advantages, the Internal Revenue Service (IRS) restricts your ability to make changes to your benefits after initial enrollment. In general, once you enroll for (or decline) coverage, your benefit elections stay in effect for the entire plan year. However, under certain circumstances, you can enroll for or change certain coverages during the year (for example, if you experience a qualifying life event that affects your, your spouse's/domestic partner's or your dependent's eligibility for plan benefits).

Qualifying Life Events

You can change certain benefit elections during the plan year if you experience a qualifying life event that results in a loss or gain of eligibility under the plan for yourself, your spouse/domestic partner or your dependent children. Changes can be made to your medical and dental coverage as long as the changes are consistent with, and correspond to, the qualifying life event.

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

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

If you experience a qualifying life event and need to change your coverage during the plan year, notify the HR Service Center within 31 days of the date of the event that necessitates the change. If you don't, you can't make a coverage change until the next annual open enrollment, unless you have another qualifying life event.

Special Enrollment Rights Under HIPAA

Special enrollment rights apply due to a loss of other coverage or a need to enroll because of a new dependent's eligibility.

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

Special Enrollment Due to Loss of Other Coverage

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

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

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

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

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

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

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

You and your dependents must meet certain other requirements as well:

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

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

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

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

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

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

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

- **Effective date of coverage:** Coverage takes effect:

  - **Upon marriage:** On the first day of the month coinciding with or following the date of marriage.
  - **Upon formation of a domestic partnership:** On the first day of the month coinciding with or following the date all of the requirements of the Chevron Affidavit of Domestic Partnership are first met.
  - **Upon birth:** On the date of the dependent's birth.
  - **Upon adoption or placement for adoption:** On the date of such adoption or placement for adoption.
  - **When adding a child (other than your own newborn or adopted child) to your coverage:** On the first day of the month coinciding with or following the date the child first becomes your dependent.

Special Enrollment Due to the Children's Health Insurance Program (CHIP)
The Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 extends and expands the State Children's Health Insurance Program (SCHIP). The Act establishes special enrollment rights for employees and their dependents that are eligible for, but not enrolled in coverage under an employer-provided group health plan (such as the Chevron health plans). You and your dependents are eligible to enroll for Chevron health coverage as long as you apply within 60 days of the date that either of the following occurs:

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

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

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

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

When Participation Begins

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

Global Choice Plan (U.S.-Payroll Expatriates) (includes prescription drug and basic vision coverage)	
Type of Coverage	**Participation Begins:**
Employee Coverage	• If you are covered under another Chevron medical plan option and are moved to a resident expatriate assignment, you and your covered dependents will automatically be enrolled as of the first day of the month following the effective date of your expatriate assignment. • On your hire date, if you enroll within 31 days of your hire date. • On the day you first become eligible, if you enroll within 31 days of the date you first become eligible. • The day you acquire a dependent child, if you enroll within 31 days of the birth or the earlier of the date of adoption or placement for adoption. • On the first day of the month coinciding with or following the date of your marriage, if you enroll within 31 days of your marriage. • On the first day of the month coinciding with or following the date all of the requirements listed on the *Chevron Affidavit of Domestic Partnership* are first met, if you enroll within 31 days of first meeting the requirements listed on the *Chevron Affidavit of Domestic Partnership*. • The following January 1, if you enroll during the open enrollment period.
Dependent Coverage	• If you and your dependents are covered under another Chevron medical plan option and you are moved to a resident expatriate assignment, you and your covered dependents will automatically be enrolled as of the first day of the month following the effective date of your expatriate assignment. • On the same day your coverage begins, if you enroll yourself and your dependents at the same time. • On the date of birth, if you enroll a newborn child within 31 days of the date he or she is born. • On the date of adoption or on the date the child is placed with you for adoption (if earlier), if you enroll the child within 31 days. • On the first day of the month coinciding with or following the date he or she becomes eligible, if you enroll a new spouse/domestic partner, child or stepchild (other than a newborn or newly adopted child) within 31 days. • The following January 1, if you enroll during the open enrollment period.
Before-Tax Contribution Plan	
Participation begins: • Generally at the same time as your participation in any one of the health plans. • The following January 1, if you enroll in the plan during the open enrollment period.	

When Participation Ends

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

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

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

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

A Snapshot of When Coverage Ends

The following chart shows additional rules regarding when coverage ends under each plan.

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

What Happens if You Die

If you die, your enrolled dependents are eligible for either continuation coverage or retiree and survivor coverage. For more information, see the Retiree and Survivor Coverage section under Continuation Coverage and COBRA Coverage.

How Much You Pay for Coverage

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

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

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

medical coverage

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

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

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

medical coverage introduction

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

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

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

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

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

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

review the cigna *certificate of coverage*

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

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

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

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

How to Contact Cigna

Customer Service

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

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

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

Courier Delivery
Cigna
300 Bellevue Parkway
Wilmington, DE 19809

Keep in Mind …

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

- Cigna administers benefits for medical services obtained inside the U.S.; medical services obtained outside the U.S.; prescription drugs obtained outside the U.S. only.
- There is a deductible under the Global Choice Plan that applies to medical benefits inside the U.S., medical benefits outside the U.S. and prescription drugs obtained outside the U.S., combined.
- There is an out-of-pocket maximum under the Global Choice Plan that applies to medical benefits inside the U.S., medical benefits outside the U.S. and prescription drugs obtained outside the U.S. combined.
- If you receive medical services in the U.S., there are different levels of benefits for network providers and out-of-network providers. Higher benefits are paid when you receive health care services from a network provider in the U.S. You always have the option of using an out-of-network provider, but plan benefits are lower if you do. Contact Cigna for a list of network providers in the U.S.

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

- Cigna uses CignaLinks in countries where it's available: Africa (South Africa, Tanzania, Kenya, Morocco, and Nigeria); Australia; Brazil; China; Hong Kong; Indonesia; Macau; Malaysia; the Middle East (Saudi Arabia, United Arab Emirates, Kuwait, Bahrain, Oman, and Qatar); Singapore; Spain; Taiwan; the United Kingdom.
- The following CignaLinks countries require a separate ID card when accessing services. The additional ID card will be issued automatically if applicable in your situation.
  - Spain
  - Middle East
  - Australia
  - Africa
  - Brazil

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

how to file a medical claim with cigna

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

Where to Get a Claim Form

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

Claims for U.S. Services

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

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

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

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

Courier Delivery
Cigna
300 Bellevue Parkway
Wilmington, DE 19809

Claims for Services Outside the U.S.

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

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

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

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

Courier Delivery
Cigna
300 Bellevue Parkway
Wilmington, DE 19809

medical claim reviews and appeals with cigna

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

Initial Review and Decision

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

Types of Claims

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

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

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

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

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

Time Limits for Processing Claims

The claims administrator must follow certain time limits when processing claims for plan benefits:

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

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

- **Plan notice of initial claim decision:** Once the plan receives a proper claim, the plan has a deadline to notify you of its decision.

Time Limits for Processing Claims *This chart describes the time limits for processing different types of claims.*			
Time Limits	**Types of Claims** **Urgent Care Health Claims**	**Preservice Health Claims**	**Postservice Health Claims**
***Plan notice* of failure to follow the proper claim procedures**	**Not later than 24 hours** after receiving the improper claim.	**Not later than 5 days** after receiving the improper claim.	**N/A**
***Your deadline* to provide additional information required by the plan to decide your claim**	**48 hours** after receiving notice that additional information is required.	**45 days** after receiving notice that additional information is required.	**45 days** after receiving notice that additional information is required.
***Plan notice* of initial claim decision**	1. **Not later than 72 hours** after receiving the initial claim, if it was proper and complete. 2. **Not later than 48 hours** after receiving additional information or after the expiration of your 48-hour deadline to provide such information to complete the claim, whichever is earlier.	1. **Not later than 15 days** after receiving the initial claim, unless an extension, up to 15 days, is necessary due to matters beyond the control of the plan. The maximum time period is 30 days total. You will be notified within the initial 15 days if an extension is needed. 2. **Not later than 15 days** after receiving the initial claim, unless you need to provide additional information. You will be notified during the initial 15-day period and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving your additional information or after the expiration of your 45-day deadline to complete the claim, whichever is earlier.	1. **Not later than 30 days** after receiving the initial claim, unless an extension, up to 15 days, is necessary due to matters beyond the control of the plan. The maximum time period is 45 days total. You will be notified within the initial 30 days if an extension is needed. 2. **Not later than 30 days** after receiving the initial claim, unless you need to provide additional information. You will be notified during the initial 30-day period, and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving your additional information or after the expiration of your 45-day deadline to complete the claim, whichever is earlier.

Concurrent Care Claims

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

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

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

Notice and Payment of Claims

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

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

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

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

You should also be aware that the claims administrators have the right to request repayment if they overpay a claim for any reason.

If Your Claim Is Denied

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

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

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

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

Before You Appeal

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

The claims administrator processes payments for claims, answers questions and reviews appeals according to the plan's provisions.

How to File an Appeal

This section describes how to file an appeal with Cigna and the time limits that apply to the different types of medical appeals.

Time Limits for Processing Appeals

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

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

First Appeal

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

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

Your appeal should include all of the following:

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

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

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

Send your appeal to:

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

Courier Delivery
Cigna
300 Bellevue Parkway
Wilmington, DE 19809

Time Limits and Procedures for Processing Your First Appeal

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

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

- The review on appeal will not afford deference to the initial denial, and it will be conducted by a fiduciary who is neither the individual who initially denied the claim that is the subject of the appeal nor the subordinate of such individual.
- If your claim is denied based in whole or in part on a medical judgment — including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate — the fiduciary reviewing the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.
- The health care professional consulted by the fiduciary reviewing the appeal will be an individual who is neither an individual who was consulted in connection with the denial of the claim that is the subject of the appeal nor the subordinate of such individual.

- Upon your request, the claims administrator will identify any medical or vocational experts whose advice was obtained on behalf of the plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

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

Notice of Decision on First Appeal

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

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

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

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

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

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

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

Customer Service

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

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

Courier Delivery
Cigna
300 Bellevue Parkway
Wilmington, DE 19809

Second Appeal

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

Time Limits and Procedures for Processing Your Second Appeal

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

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

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

Notice of Decision on Second Appeal

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

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

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

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

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

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

Requesting an External Review

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

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

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

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

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

Expedited External Review

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

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

To request an expedited external review, contact:

Customer Service

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

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

Courier Delivery
Cigna
300 Bellevue Parkway
Wilmington, DE 19809

Administrative Power and Responsibilities

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

if you're covered by more than one health plan

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

How It Works

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

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

If You or a Dependent Is Covered by More Than One Plan

A plan other than your Global Choice Plan will be the primary payer if any of the following conditions applies to the other plan:

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

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

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

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

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

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

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

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

Your Children's Coverage if You're Divorced or Separated

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

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

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

prescription drug coverage

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

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

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

prescription drug introduction

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

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

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

This section only discusses prescription drug coverage. For more information about medical and vision coverage see the corresponding sections in this SPD.

prescription drugs
obtained OUTSIDE the U.S.
global choice plan - cigna

review the cigna *certificate of coverage*

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

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

You should carefully review the Certificate of Coverage before obtaining services to verify what is covered and make sure you comply with any requirements. The Certificate of Coverage is available online at **hr2.chevron.com** on the Internet. Go to the **Summary Plans Descriptions** page or choose **Medical** from **Health Plans** on the top navigation. You can also request a copy:

Customer Service

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

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

Courier Delivery
Cigna
300 Bellevue Parkway
Wilmington, DE 19809

how to file a prescription drug claim with cigna

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

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

Where to Get a Claim Form

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

- Cigna website at **www.cignaenvoy.com.**
- The **Forms Library** at **hr2.chevron.com**.

Customer Service

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How to Contact Cigna

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- www.cignaenvoy.com

prescription drug claims review and appeals with cigna

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

Initial Review and Decision

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

Types of Claims

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

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

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

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

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

Time Limits for Processing Claims

The claims administrator must follow certain time limits when processing claims for plan benefits:

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

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

- **Plan notice of initial claim decision:** Once the plan receives a proper claim, the plan has a deadline to notify you of its decision.

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

Concurrent Care Claims

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

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

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

Notice and Payment of Claims

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

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

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

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

You should also be aware that the claims administrators have the right to request repayment if they overpay a claim for any reason.

If Your Claim Is Denied

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

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

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

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

Before You Appeal

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

The claims administrator processes payments for claims, answers questions and reviews appeals according to the plan's provisions.

How to File an Appeal

This section describes how to file an appeal with Cigna and the time limits that apply to the different types of prescription drug appeals.

Time Limits for Processing Appeals

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

Time Limits	Types of Claims: Urgent Care Health Claims	Preservice Health Claims	Postservice Health Claims
Your deadline to file a first appeal	**180 days** after receiving the claim denial notice.	**180 days** after receiving the claim denial notice.	**180 days** after receiving the claim denial notice.
Plan notice of first appeal decision	**Not later than 24 hours** after receiving an appeal.	**Not later than 15 days** after receiving an appeal.	**Not later than 30 days** after receiving an appeal.
Your deadline to file a second appeal	Not applicable.	**90 days** after receiving the first appeal denial notice.	**90 days** after receiving the first appeal denial notice.
Plan notice of second appeal decision	Not applicable.	**Not later than 15 days** after receiving a second appeal.	**Not later than 30 days** after receiving a second appeal.
***Your deadline* to request an External Review**	**Four** months after receiving the appeal denial notice	**Four** months after receiving the second appeal denial notice	**Four** months after receiving the second appeal denial notice
***IRO notice* of External Review Decision**	**Not later than 72 hours** after receiving the request	**Not later than 45 days** after receiving the request for external review	**Not later than 45 days** after receiving the request for external review

First Appeal

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

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

Your appeal should include all of the following:

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

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

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

Send your appeal to:

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

Courier Delivery
Cigna
300 Bellevue Parkway
Wilmington, DE 19809

Time Limits and Procedures for Processing Your First Appeal

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

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

- The review on appeal will not afford deference to the initial denial, and it will be conducted by a fiduciary who is neither the individual who initially denied the claim that is the subject of the appeal nor the subordinate of such individual.
- If your claim is denied based in whole or in part on a medical judgment — including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate — the fiduciary reviewing the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.
- The health care professional consulted by the fiduciary reviewing the appeal will be an individual who is neither an individual who was consulted in connection with the denial of the claim that is the subject of the appeal nor the subordinate of such individual.
- Upon your request, the claims administrator will identify any medical or vocational experts whose advice was obtained on behalf of the plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

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

Notice of Decision on First Appeal

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

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

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

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

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

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

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

Customer Service

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

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

Courier Delivery
Cigna
300 Bellevue Parkway
Wilmington, DE 19809

Second Appeal

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

Time Limits and Procedures for Processing Your Second Appeal

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

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

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

Notice of Decision on Second Appeal

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

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

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

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

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

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

Requesting an External Review

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

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

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

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

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

Expedited External Review

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

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

To request an expedited external review, contact:

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Administrative Power and Responsibilities

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

prescription drugs
obtained INSIDE the U.S.
chevron prescription drug program – express scripts

overview of prescription drug benefit (express scripts)

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

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

Program Feature	Retail Pharmacy (U.S. network)	Retail Pharmacy (U.S. out-of-network)**	Home Delivery Service
Deductible (separate from medical deductible)	$150 individual $300 family	$150 individual $300 family	No deductible
Annual Out-of-Pocket Maximum (separate from medical plans' annual out-of-pocket maximum)	$1,800 individual $3,600 family	$1,800 individual $3,600 family	$1,800 individual $3,600 family
	After you pay the deductible, the plan pays:	**After you pay the deductible, the plan pays:**	**The plan pays:**
Generic Drugs	100% after you pay a $5 copayment for each 31-day supply	100% of network price after you pay a $5 copayment for each 31-day supply.	100% after you pay a $15 copayment for each 92-day supply
Preferred Brand-Name Drugs*	80% You pay a $15 minimum for each 31-day supply	80% of network price You pay a $15 minimum for each 31-day supply.	85% You pay a $35 minimum for each 92-day supply.
Nonpreferred Brand-Name Drugs*	70% You pay a $30 minimum for each 31-day supply	70% of network price You pay a $30 minimum for each 31-day supply.	75% You pay a $75 minimum for each 92-day supply.
Supply Limit	Up to a 365-day supply	Up to a 365-day supply	Up to a 365-day supply

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

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

prescription drug deductible (express scripts)

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

Coverage Tier	Annual Deductible
You Only	$150
You and Family (two or more)	$300

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

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

- Amounts you pay for prescriptions through the home delivery pharmacy program.
- The difference you pay between the cost of the generic and brand-name drug, if you choose a brand-name drug when a generic is available.
- The difference between the network pharmacy price and the out-of-network pharmacy price if you use an out-of-network pharmacy (or you don't provide your ID at a network pharmacy).
- Charges for services or supplies that aren't covered under the Prescription Drug Program, including drugs or services obtained outside the U.S. (may be covered by the medical portion of the Global Choice Plan).

prescription drug out-of-pocket maximum feature (express scripts)

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

Coverage Tier	Annual Out-of-Pocket Maximum
You Only	$1,800
You and Family (two or more)	$3,600

Each covered individual has an out-of-pocket maximum equal to the You Only amount. For example, if you choose the You and Family coverage tier, your annual out-of-pocket maximum is satisfied when the family's accumulation of out-of-pocket maximums reaches $3,600, with no more than $1,800 applied for each family member.

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

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

covered medication (express scripts)

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

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

In addition, the program covers:

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

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

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

- Smoking deterrents (covered at 100%, with no deductible).
- Prescribed FDA approved female contraceptive methods including prescribed contraceptives which can be purchased over-the-counter (covered at 100%, with no deductible).
- Prescription vitamins (not over-the-counter), including prenatal vitamins.
- Retin-A, covered up to age 34.
- Needles, syringes and injectable medications.
- Fluoride supplementations for dependents six months old through age 5 (covered at 100%, with no deductible).

- Doctor prescribed medications for preventive care as required by the Patient Protection and Affordable Care Act with no deductible for certain generic over-the-counter drugs and generic prescription drugs. Examples of the medications are:

    - Aspirin to prevent cardiovascular events (men age 45 – 79, women age 55 – 79)

    - Aspirin for preeclampsia

    - Folic Acid (women through age 50)

    - Vitamin D (men and women over the age of 65 who are at increased risk for falls)

    - Bowel Preps (men and women age 50 – 75); coverage is for generic and single-source prescription drugs and generic over-the-counter products. Limited to a maximum of two prescriptions per 365 days.

For more information about which drugs aren't covered under the Prescription Drug Program, see Drugs That Aren't Covered in this section.

Home Delivery Requirement for Specialty Maintenance Drugs

The second or later fill of a Specialty Drug that is a maintenance drug (as specified by Express Scripts) is covered after the first fill only if obtained from the Home Delivery Pharmacy Program.

Managed Prior Authorization and Dose Quantity Management (DQM)

Drugs within certain therapy classes are covered by the Prescription Drug Program only if prescribed for certain uses or only up to quantity level limitations determined by Express Scripts. Which therapies or specific prescription drugs that require Managed Prior Authorization, and/or are subject to quantity limits can be obtained at any time from Express Scripts or on the ESI website.

Preferred Drug Step Therapy Program

Prescription drugs to treat specified disease states are covered by the Prescription Drug Program only if preferred drugs, including generics, when clinically appropriate, are utilized first. These drugs require authorization of Express Scripts under the Preferred Drug Step Therapy Program.

The current list of prescription drugs that require authorization of Express Scripts under the Preferred Drug Step Therapy Program can be obtained at any time from Express Scripts.

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

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

Medical Channel Management

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

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

The list of specialty drugs subject to Medical Channel Management may change so you should check the list before you fill a prescription for a specialty medication. Call 1-800-987-8368 for a complete list of medications subject to this program.

Hepatitis Cure Value Program

Prior authorization under the Express Scripts Hepatitis Cure Value Program is required for prescription drugs used to treat Hepatitis C. The Hepatitis Cure Value Program is a separate prior authorization program that pairs formulary and utilization management with exclusive distribution from the Accredo® Specialty Pharmacy.

Cholesterol Care Value Program

Prior authorization under the Express Scripts Cholesterol Care Value Program is required for cholesterol-lowering maintenance drugs that offer an alternative to statins called PCSK9 inhibitors. These drugs are self-injectable specialty medications. The Cholesterol Care Value Program is a separate prior authorization program that features a clinical review process by a dedicated Express Scripts clinical team of pharmacists who specialize in cardiovascular disease and enhanced care for CPDP Members and CPDP Dependents who are starting PCSK9s

drugs that aren't covered (express scripts)

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

- Drugs not listed on the National Preferred Formulary.
- Nonfederal legend drugs, including over-the-counter medications, unless otherwise specified in the Prescription Drug Program as covered.
- Anorexiants and appetite suppressants.
- Topical fluoride products except as required by the Patient Protection and Affordable Care Act.
- Retin-A, Avita and Altinac creams after age 34, unless prior authorization is obtained from Express Scripts.
- Blood glucose testing monitors (covered under the medical portion of the Global Choice Plan).
- Therapeutic devices or appliances (including durable medical equipment).
- Drugs designed solely to promote or stimulate hair growth (including Rogaine and Propecia) or for cosmetic purposes only (such as Renova).
- Allergy serums (may be covered under another part of the Global Choice Plan).
- Immunization agents and vaccines not covered by the ACA.
- Biologicals and blood or blood plasma products.
- Drugs designated under federal law for investigational use or as experimental drugs, even if you're charged for the drugs.
- Refills in excess of the number prescribed by your doctor or dispensed more than one year after your doctor gave you the prescription.
- Drugs that are prescribed as part of your treatment while you are an inpatient in any facility, such as a hospital or skilled nursing facility that has a facility for dispensing drugs on its premises.
- Charges for the administration or injection of any drug.
- Drugs or services obtained outside the U.S. (which may be covered by the medical portion of the Global Choice Plan).
- Refills of Specialty maintenance medications purchased at a retail pharmacy.
- Nonsedating antihistamines.
- Most compound drugs (except pediatric compounds).
- Hepatitis C drugs Sovaldi for genotype 1 patients and Olysio® (simeprevir); provided, however, that use of these drugs may be approved through a formulary exception.
- Charges for virtual visits.

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

when you go to a network pharmacy (in the U.S.) (express scripts)

When you are on an expatriate assignment, medications cannot be sent through international mail (including pouch mail). In addition, Chevron cannot control the delivery method or schedule of the home delivery pharmacy. If you require medication on a regular basis, you'll need to plan ahead for your trips back to the United States. If your time is limited, you're encouraged to use a U.S. network retail pharmacy to fill the prescription. You can fill prescriptions for **up to a 365-day supply** of covered medication at any Express Scripts network pharmacy prior to departure back to your host country. Here's how:

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

2. Show your prescription ID card to the pharmacist or provide your Express Scripts ID number when you hand in your prescription. Your eligibility will be confirmed by a computerized system. Generally, after you meet your deductible, you will pay the following:

   — $5 for each 31-day supply of generic drugs.
   — 20 percent of the discounted cost for preferred brand-name drugs.
   — 30 percent of the discounted cost for nonpreferred brand-name drugs.

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

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

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

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

when you go to an out-of-network pharmacy (in the U.S.) (express scripts)

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

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

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

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

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

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

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

home delivery pharmacy program (express scripts)

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

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

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

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

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

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

How to Order Medication by Mail

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

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

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

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

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

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

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

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

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

how to file a prescription drug claim with express scripts

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

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

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

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

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

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

You can call Express Scripts Member Services at 1-800-987-8368 to request a claim form or you can obtain forms from Express Script's website at **www.express-scripts.com**. Claim forms are also available from the **Forms Library** at **hr2.chevron.com**.

When you fill out the claim form, use your full name and your member ID number located on your Express Scripts ID card. Attach the original receipt from the pharmacy. The receipt must contain the following information:

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

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

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

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

You also should be aware that Express Scripts has the right to request repayment if it overpays a claim for any reason.

prescription drug claim reviews and appeals with express scripts

Initial Review and Decision

Claims for Prior Authorization and Dispense as Written (DAW) Prescription Drug Benefits

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

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

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

Urgent Care Claims

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

If your coverage request is an urgent care claim, Express Scripts will make a determination on a prescription presented at a retail network pharmacy or submitted to a home delivery pharmacy not later than 72 hours after receiving the initial claim, if it was properly made and no additional information is required. If additional information is required to make the determination, the prescribing doctor will be contacted by fax or phone with a request for the necessary information. Your doctor will have 48 hours to provide the additional information requested. In this case, Express Scripts will make a determination not later than 48 hours after receiving the additional information or after the expiration of the 48-hour deadline to provide such information, whichever is earlier.

Claims for Other Prescription Drug Benefits

If you present a prescription for a drug that does not require prior authorization or for a drug for which your doctor has not requested "Dispensed as Written," either at a retail pharmacy or through the home delivery pharmacy, and your request is denied, you can contact Express Scripts for an explanation. If you are not satisfied with the explanation provided by Express Scripts, you can file a claim for benefits by writing to Express Scripts at the following address:

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

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

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

If Your Prescription Drug Claim Is Denied

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

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

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

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

How to File an Appeal

This section describes how to file an appeal with Express Scripts and the time limits that apply to the different types of prescription drug appeals.

Time Limits for Processing Prescription Drug Appeals This chart describes time limits for processing different types of prescription drug appeals.			
	Types of Claims		
Time Limits	**Urgent Care Prescription Drug Claims**	**All Other Prescription Drug Claims (except member-submitted paper claims)**	**Member-Submitted Paper Claims for Prescription Drugs**
***Your deadline* to file a first appeal**	**180 days** after receiving the claim denial notice.	**180 days** after receiving the claim denial notice.	**180 days** after receiving the claim denial notice.
***Plan notice* of first appeal decision**	**Not later than 72 hours** after receiving an appeal.	**Not later than 15 days** after receiving an appeal.	**Not later than 30 days** after receiving an appeal.
***Your deadline* to file a second appeal**	**N/A**	**90 days** after receiving the first appeal denial notice.	**90 days** after receiving the first appeal denial notice.
***Plan notice* of second appeal decision**	**N/A**	**Not later than 15 days** after receiving a second appeal.	**Not later than 30 days** after receiving a second appeal.
***Your deadline* to request an External Review**	**Four** months after receiving the appeal denial notice	**Four** months after receiving the second appeal denial notice	**Four** months after receiving the second appeal denial notice
***IRO notice* of External Review Decision**	**Not later than 72 hours** after receiving the request for external review.	**Not later than 45 days** after receiving the request for external review	**Not later than 45 days** after receiving the request for external review

First Appeal

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

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

Your written first appeal should include the following information:

- Your full name even if the claim is for your dependent.
- Your member id number located on your Express Scripts ID Card.

- Your phone number.
- The prescription drug for which coverage has been denied.
- An explanation of why you believe the prescription drug should be covered.
- Any supporting information or documentation.

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

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

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

Time Limits and Procedures for Processing Your First Appeal

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

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

Notice of Decision on First Appeal

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

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

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

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

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

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

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

Second Appeal

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

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

Your second appeal must be submitted in writing within 90 days after your first appeal is denied. Your written second appeal should include the following information:

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

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

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

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

Time Limits and Procedures for Processing Your Second Appeal

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

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

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

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

Notice of Decision on Second Appeal

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

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

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

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

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

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

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

Requesting an External Review

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

A de minimis (small) deviation from strict adherence to the internal claims and appeals procedure on the part of the relevant claims administrator or review panel that does not cause, or is not likely to cause, prejudice or harm to the claimant will not waive the requirement to exhaust the internal claims and review procedure before obtaining an external review or filing a lawsuit. The claims administrator shall provide an explanation of such deviation within 10 days of the request of the claimant. If a request for external review is denied on account of the failure to exhaust the internal claims and appeals process when a de minimis deviation is involved, the claimant shall have the right to pursue the internal process.
You or your authorized representative can request an external review in writing or verbally to Express Scripts by following instructions in your denial letter or contacting Express Scripts at:

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

1-800-753-2851
1-888-235-8551 (fax)

You must request the external review within four months after the date of receipt of a denial of your second appeal. Express Scripts will provide an external review procedure through an accredited Independent Review Organization (IRO) after determining the following:

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

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

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

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

Expedited External Review

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

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

To request an expedited external review, contact Express Scripts:

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

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

Administrative Power and Responsibilities

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

if you're covered by more than one health plan prescription drug program

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

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

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

basic vision coverage

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

- Chevron Vision Program - VSP Vision Care (VSP)

overview of vision benefits (VSP)

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

Basic Vision through VSP Vision Care (VSP)

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

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

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

review the VSP *evidence of coverage* document

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

- VSP at 1-800-877-7195 (inside the U.S.).
- If outside the U.S. and unable to access the toll-free number you may contact VSP by telephone at (916) 851-5000 (press “0” for operator assistance).
- Go to **www.vsp.com/go/chevron** on the Internet.

how to use your basic vision benefit

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

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

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

basic vision claims

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

- VSP at 1-800-877-7195 (inside the U.S.).
- If outside the U.S. and unable to access the toll-free number you may contact VSP by telephone at (916) 851-5000 (press “0” for operator assistance).
- Go to **www.vsp.com/go/chevron** on the Internet.

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

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

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

wellness programs

wellness programs

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

other plan information

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

administrative information

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

Employer Identification Number (EIN)

The employer identification number for the health plans is 94-0890210.

Plan Sponsor and Plan Administrator

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

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

Chevron Global Choice Plan
This plan is part of the Omnibus Health Care Plan.

Plan number: 560

Claims Administrator/Insurer:
Cigna (Group #05721A008)

For services outside the U.S.: Cigna | P.O. Box 15050 | Wilmington, DE 19850-5050 | U.S.A.

For prescription drugs obtained outside the U.S.: Cigna | P.O. Box 15050 | Wilmington, DE 19850-5050 | U.S.A.

For services inside the U.S.: Cigna | P.O. Box 15050 | Wilmington, DE 19850-5050 | U.S.A.

Type of Administration: Insurer Administration

Type of Plan: Medical Benefit

Chevron Corporation Prescription Drug Program
This program is part of the Global Choice and Omnibus Health Care Plan.

Plan number: 560

Claims Administrator:
For prescription drugs obtained inside the U.S.: Express Scripts | P.O. Box 2277 | Lee's Summit, MO 64063-2277 www.Express-Scripts.com

Type of Administration: Contract administration

Type of Plan: Medical (Prescription Drug) Benefit

Chevron Corporation Vision Program
This program is part of the Global Choice and Omnibus Health Care Plan.

Plan number: 560

Insurer:
Out-of-network claims: P.O. Box 997105 | Sacramento, CA 95899-7105 www.vsp.com

Type of Administration: Insurer Administration

Type of Plan: Vision Benefit

Chevron Corporation Omnibus Health Care Plan

Plan number: 560

Type of Administration: Contract Administration

Type of Plan: Health Plan

Before-Tax Contribution Plan

Plan number: 721

Type of Administration: Company administered

Type of Plan: Health Contribution (Cafeteria Plan)

Agent for Service of Legal Process

Any legal process related to the plans should be served on:

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

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

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

Plan Amendments and Changes

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

Participating Companies

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

Collective Bargaining Agreements

If a union represents you, you're eligible for the health care plans, provided both of the following apply:

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

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

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

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

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

Incorrect Computation of Benefits

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

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

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

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

Recovery of Overpayments

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

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

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

Future of the Plans

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

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

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

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

No Right to Employment

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

Plan Year

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

Administrative Power and Responsibilities

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

your ERISA rights

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

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

Receive Information About Your Plan and Benefits

You have the right to:

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

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

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

Continue Group Health Plan Coverage

You have a right to continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. For information regarding your continuation coverage rights, review the Continuation Coverage and COBRA Coverage section and the documents governing the plan.

If You Have a Pre-existing Condition

If you have creditable coverage from another plan, any exclusionary periods of coverage for pre-existing conditions under your group health plan may be reduced or eliminated. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when any of the following occurs:

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

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

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

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain (without charge) copies of documents related to the decision, and to appeal any denial — all within certain time schedules.

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

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

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

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

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

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

Assistance With Your Questions

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

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

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

- 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 to recover a benefit under a plan, provided all of the following have been completed:

- You initiate a claim as required by the plan.
- You receive a written denial of the claim.
- You file a timely written request for a review of the denied claim with the plan administrator or the claims administrator (or you receive written notification that the claim has been denied on appeal).
- If the plan provides for two levels of appeal, you file a timely written request for a second review of the denied claim with the plan administrator or the claims administrator (or you receive written notification that the claim has been denied on second appeal).
- If the plan provides for external review, you file a timely request for an external review of the denied claim with the plan administrator or the claims administrator.
- You receive written notification that the claim has been denied on final review.

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

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

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

The plan administrator is the appropriate party to sue for all Chevron Corporation benefit plans.

other legislation that can affect your benefits

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

Newborns' and Mothers' Health Protection Act of 1996

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

Reconstructive Surgery and Procedures

Consistent with the Women's Health and Cancer Rights Act of 1998, if you have a mastectomy and elect reconstructive surgery in connection with the mastectomy, coverage is provided for *all* of the following:

- Reconstruction of the breast on which the mastectomy is performed.
- Reconstruction and surgery of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment remedies for physical complications during all stages of the mastectomy, including lymphedemas.

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

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA was designed to make health care coverage easier to obtain for people who switch jobs or are between jobs. Companies are required to provide plan members with specific information about HIPAA when their medical coverage ends.

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

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

Free or Low-Cost Health Coverage to Children and Families

Offered by Medicaid and the Children's Health Insurance Program (CHIP)

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

- **If you or your dependents are already enrolled in Medicaid or CHIP** and you live in a participating state, contact your state's Medicaid or CHIP office to find out if premium assistance is available.

- **If you or your dependents are not currently enrolled in Medicaid or CHIP**, but you think you or your dependent(s) might be eligible for either of these programs, contact your state's Medicaid or CHIP office. You can also call 1-877-KIDS NOW (1-877-543-7669) or visit **www.insurekidsnow.gov** to learn how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, then Chevron is required to allow you and your dependents to enroll in a company-offered plan. To qualify for this special enrollment opportunity, you must be eligible for Chevron coverage, but not already enrolled. **In addition, you must contact the Human Resources (HR) Service Center and request Chevron health coverage within 60 days of being determined eligible for Medicaid or CHIP premium assistance**. If you enroll timely, Medicaid or CHIP will subsidize, or pay for, a portion of the Chevron health plan premium cost.

If you have any questions

Please call the HR Service Center to speak with a Customer Service Representative. Customer Service Representatives are available from 6 a.m. to 5 p.m., Pacific time (8 a.m. to 7 p.m., Central time), Monday through Friday, except on holidays.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2017. You should contact your State for further information on eligibility

ALABAMA – Medicaid	**COLORADO** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	**FLORIDA** – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218

LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid

Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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

third party responsibility

Payment of Certain Benefits Subject to Full Right to Subrogation and Reimbursement

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

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

First Right of Recovery

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

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

Furthermore, the health plans' rights to reimbursement, restitution, to an equitable lien by contract, and as beneficiary of a constructive trust shall in no way be affected, reduced, compromised, or eliminated by any state law, common law, or equitable doctrines limiting its rights, including, but not limited to, the make-whole doctrine, common fund doctrine, comparative fault rule, contributory negligence rule, unjust enrichment doctrine, or any similar doctrine or rule established by common law or by statute, or any other defense which may act to reduce the amount the health plans' may be entitled to recover.

Granting of an Equitable Lien by Contract

At the time the health plans pay benefits, you or your covered dependent grants to the health plans (as a condition of such payment) an equitable lien by contract in any property described above. This means that you grant the health plans a first right to any property (including money) that you recover as a result of the event that caused the benefits to be paid. This right to an equitable lien by contract exists without regard to the identity of the property's source or holder at any particular time, or whether at any particular time the property exists, is segregated, or you or your covered dependent has any rights to it.

Creation of Constructive Trust

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

Your Responsibilities

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

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

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

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

- To cooperate with the health plans and take any action that may be necessary to protect the health plans' right to recovery.

Your Notice Obligations

You or your covered dependent agrees to timely notify the health plans of:

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

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

No Duty to Independently Sue or Intervene

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

Recovery of Overpayments

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

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

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

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

continuation coverage and COBRA coverage

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

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

introduction

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

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

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

What Is Continuation Coverage?

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

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

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

Conversion Coverage

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

who’s eligible for continuation coverage

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

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

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

qualifying events

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

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

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

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

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

Special Rule for Bankruptcy of the Employer

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

Chevron Must Give Notice of Some Events

Chevron has the responsibility to notify BenefitConnect COBRA, which handles Chevron's continuation coverage administration, when any of the following occurs:

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

You Must Give Notice of Some Events

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

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

The following information should be included in the notice:

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

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

You should provide your notice to the Chevron HR Service Center. Your personal identification number (PIN) will be required when reporting the event by telephone. Additionally, you can mail your notice to the following address:

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

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 BenefitConnect COBRA within 31 days of acquiring the new dependent. If you fail to do so, your new dependent will not be considered a qualified beneficiary for purposes of continuation coverage and may not be covered under a Chevron health plan until a subsequent annual open enrollment period, if applicable.

Electing Continuation Coverage

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

how much continuation coverage costs

In most cases, you or your dependents pay 100 percent, plus a 2 percent administrative fee, of the cost of health plan coverage that's continued. The cost of coverage will vary based on the plans you're enrolled in and how many family members are enrolled. (If you're eligible for continuation coverage because you're on a Long Union Business Leave that's scheduled to last more than 31 days, you're not required to pay the 2 percent administrative fee.) If you or your dependents are eligible for the 11-month disability extension and the disabled qualified beneficiary elects continuation coverage, you or your dependents will pay 150 percent of the cost of health plan coverage that's continued for months 19 through 29.

You or your dependents must pay Chevron for this coverage as long as it's in effect. Your first payment for continuation coverage is due within 45 days after the date of your election. (This is the date the continuation coverage election form is postmarked, if mailed.) If you do not make your first premium payment for continued coverage within 45 days, you will lose all continuation coverage rights under the plan.

After that, payments are due on the first day of each month. For example, payment for January coverage is due on January 1. Coverage will be canceled and can't be reinstated if a payment is 30 days overdue. It is the qualified beneficiary's responsibility to make timely payments, even if he or she does not receive a payment coupon.

Regular monthly COBRA payments should be mailed to BenefitConnect COBRA. Contact BenefitConnect COBRA for payment information.

when continuation coverage starts

Your regular health plan coverage will end on the last day of the month in which a qualifying event occurs. If you or your dependents enroll for continuation coverage within 60 days after regular coverage ends (or, if later, within 60 days after the date the continuation coverage election notice is sent to you) upon timely receipt of the full amount of the required first payment for continuation coverage, your or your dependent's Chevron health plan coverage will be reinstated retroactive to the date Chevron health plan coverage ended. If you fail to meet these deadlines, you or your dependents will waive the right to enroll for continuation coverage.

How Long Continuation Coverage Lasts

You, your spouse, your domestic partner and your covered dependents may qualify for up to 18 months of health care continuation coverage if you qualify due to one of the following qualifying events:

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

Your covered spouse, your domestic partner and your covered dependents may qualify for up to 36 months of health care continuation coverage if they qualify due to one of the following qualifying events:

- You die.
- An enrolled child or other dependent no longer meets the Chevron health plans' eligibility requirements.
- You and your spouse get a divorce.
- You and your domestic partner end your domestic partnership.

Your survivor and his or her covered dependents may qualify for up to 36 months of health care continuation coverage when:

- Your survivor's Chevron retiree and survivor coverage ends because your survivor adds a new spouse or another dependent to health coverage.

Continuation coverage generally lasts for up to a total of 18 months when the qualifying event is the end of employment or reduction of the employee's hours of employment. This 18-month period of continuation coverage can be extended in two ways: disability extension or second qualifying event extension.

Disability extension of 18-month period of continuation coverage
The 18-month period may be extended for you and your covered family members if the Social Security Administration determines that you or another family member who is a qualified beneficiary is disabled at any time during the first 60 days of continuation coverage. Coverage for all family members who are qualified beneficiaries, as a result of the same qualifying event, can be extended for up to an additional 11 months (for a total of 29 months) if all of the following requirements are met:

- Your continuation coverage qualifying event was an employee's termination of employment (for any reason other than gross misconduct) or a reduction in hours so that the employee (and you) was no longer eligible for Chevron health care benefits.

- The disability started at some time before the 60th day of continuation coverage and lasts at least until the end of the 18-month period of continuation coverage.

- A copy of the Notice of Award from the Social Security Administration is provided to the HR Service Center within 60 days of receipt of the notice and before the end of the initial 18 months of continuation coverage.

- If the disabled qualified beneficiary elects continuation coverage, you must pay an increased premium of 150 percent of the monthly cost of health plan coverage that's continued, beginning with the 19th month of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If another qualifying event occurs during the first 18 months of continuation coverage, your spouse/domestic partner and dependent children can receive up to an additional 18 months of continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is timely provided to the HR Service Center as described in You Must Give Notice of Some Events under How to Enroll in this Continuation Coverage and COBRA Coverage section.

This extension may be available to your spouse/domestic partner and any dependent children receiving continuation coverage if you die, get divorced or terminate your domestic partner relationship or if your dependent child is no longer eligible under the terms of a Chevron health plan as a dependent child. A second event will be considered a qualifying event only if the second event would have caused your spouse/domestic partner or dependent child to lose coverage under the health plan had the first qualifying event not occurred.

Extension Due to Medicare Eligibility
When the qualifying event is the end of employment (for reasons other than gross misconduct) or reduction of the employee's hours of employment, and the employee became entitled to Medicare (Part A, Part B or both) benefits within 18 months prior to the qualifying event, continuation coverage for qualified beneficiaries (other than the employee) can last until 36 months after the date of Medicare entitlement. In order to qualify for this extension, you must provide the HR Service Center with a copy of your Medicare card showing the date of Medicare entitlement.

In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect continuation coverage.

when continuation coverage ends

Continuation coverage may be terminated before the maximum period if one of the following occurs:

- The premium for your continuation coverage is not paid on time.
- If after electing continuation coverage, you become covered by another group health plan, unless the plan contains any exclusions or limitations with respect to any pre-existing condition you or your covered dependents may have.
- If after electing continuation coverage, you first become eligible for and enroll in Medicare Part A, Part B or both.
- You extend coverage for up to 29 months due to a qualified beneficiary's disability and there has been a final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. In this case, continuation coverage will end on the first of the month that begins more than 30 days after the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. This will be the case only if the qualified beneficiary has been covered by continuation coverage for at least 18 months.
- Chevron no longer provides group health coverage to any of its eligible employees or eligible retirees.

Continuation coverage also may be terminated early for any reason the Chevron health plans would terminate coverage of a participant or beneficiary not receiving continuation coverage (for example, if you commit fraud or make an intentional misrepresentation of a material fact).

continuation coverage vs. retiree and survivor coverage

If you qualify as an eligible retiree at the time of your termination of employment with Chevron, you will have the option to elect either one of the following for you and your covered dependents:

- Retiree and survivor coverage.
- Continuation coverage.

The costs for retiree and survivor coverage and continuation coverage may differ. You should carefully review the information provided to you by Chevron at the time you terminate employment with Chevron.

Although you have the option to elect either retiree and survivor coverage, or continuation coverage, generally, if you don't enroll in retiree and survivor coverage when you first become eligible, then you can only elect retiree and survivor coverage during an annual open enrollment period. However, there are a few exceptions as follows:

- This provision does not apply if you were a former employee who was eligible for both subsidized COBRA and retiree medical coverage and initially elected subsidized COBRA coverage. In this case you can immediately enroll in retiree medical coverage after your subsidized COBRA coverage ends, provided you do so within 31 days of the subsidized COBRA coverage ending.
- This provision does not apply if you and your dependents are covered by another Group Plan upon your death. In this case, your survivors are able to elect coverage under the retiree and survivor plan, provided they do so within 31 days of your death.

Elections you make during an open enrollment period will become effective at the beginning of the next calendar year, unless you have a qualifying life event (for example, you get married or divorced) that is subject to midyear special enrollment rights.

Continuation Coverage Considerations

If you don't elect continuation coverage …
If you qualify as an eligible retiree and *don't* elect continuation coverage, you and your eligible dependents that were enrolled in a Chevron health plan on the day before the qualifying event will be automatically enrolled in retiree and survivor coverage with Chevron. Retiree and survivor coverage will be effective retroactively to the first day of the month following your termination of employment. You may still elect continuation coverage during the 60-day election period. If you elect continuation coverage after you have been automatically enrolled in retiree and survivor coverage, your retiree and survivor coverage will be retroactively canceled.

If you elect continuation coverage …
If you qualify as an eligible retiree at the time of your termination of employment with Chevron and you elect continuation coverage, you may enroll in retiree and survivor coverage at a later time, but only during an annual open enrollment period. However, there are a few exceptions that apply – please see above.

Special exceptions if you are eligible for subsidized COBRA …
If you are eligible for both retiree medical coverage and subsidized COBRA and you initially elect subsidized COBRA coverage, some of the provisions above do not apply to you:

- You can immediately enroll in retiree and survivor coverage after your subsidized COBRA coverage has ended, as long as you do so within 31 days of the subsidized coverage ending. You do not have to wait for an open enrollment period.
- If you die while enrolled in subsidized COBRA, your survivors can immediately enroll in retiree and survivor coverage after subsidized COBRA coverage has ended, as long as they do so within 31 days of the subsidized coverage ending.
- If you die while enrolled in another employer's group health plan, your survivors can immediately enroll in retiree and survivor coverage after your death, as long as they do so within 31 days of your death.

Retiree and Survivor Coverage Considerations

If you die, your enrolled dependents are eligible for either continuation coverage (described under Continuation Coverage and COBRA Coverage in this section) or survivor coverage under Chevron's health plans. Chevron currently pays a portion of the cost for survivor coverage. However, if your enrolled dependent(s) elect continuation coverage, they must pay the entire cost plus a 2 percent administrative fee.

Your enrolled dependents may elect survivor coverage within 31 days of your death. Upon timely receipt of any required premiums, an election of survivor coverage will be effective retroactive to the day after the day that the survivor's (and his or her covered dependent(s), if applicable) coverage under Chevron's health plans terminates. In the event that such survivor subsequently elects continuation coverage within the election period, such survivor's (and his or her eligible dependent(s), if applicable) survivor coverage shall be canceled retroactive to the day it commenced.

Survivor coverage for your spouse/domestic partner can continue until he or she dies, cancels survivor coverage or does not make timely premium payments. Survivor coverage can continue if a surviving spouse/domestic partner remarries or enters into a new domestic partner relationship, but the new spouse/domestic partner or any other dependents cannot be added to any Chevron health plan. If your spouse wishes to add his or her new spouse or other dependent to the plan, survivor coverage ends, and up to 36 months of continuation coverage becomes available.

Survivor coverage for your enrolled children can continue until the child reaches age 26 (unless incapacitated), or is no longer eligible according to the eligibility provisions for the health plans for reasons other than your death. Please see the Eligible Children and Other Dependents section for details on eligibility. If your dependent wishes to add his or her new spouse or other dependent to the plan, survivor coverage ends, and up to 36 months of continuation coverage becomes available.

Survivor coverage will also end early if the survivor fails to timely pay any required premiums for coverage or as of the date the survivor has received the maximum benefit under a particular Chevron health plan. Survivor coverage will also end if Chevron ceases to provide any health plan for any of its employees or retirees. Survivor coverage may also be terminated due to fraud or intentional misrepresentation of a material fact.

If your covered spouse or covered child becomes ineligible for survivor coverage, he or she can continue Chevron health plan coverage for up to 36 months under the terms of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Pursuant to Chevron policy, your covered domestic partner and your domestic partner's covered dependent children may also be eligible for continuation coverage that's similar to COBRA if they become ineligible for survivor coverage under the Chevron health plans.

If a surviving spouse/surviving domestic partner or surviving dependent child waives all health plan coverage, they become permanently ineligible for future Chevron health plan coverage with respect to your death.

additional rights and rules

Special Rule:
Periods of Continuation Coverage Subject to the Uniformed Services Employment and Reemployment Rights Act of 1994

If you are on a Military Service Leave, you will be permitted to continue health plan coverage for you, your spouse and your dependent children in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and pursuant to Chevron policy.

While you are on a Military Service Leave, your health plan coverage may continue. Chevron will continue to pay its normal company contribution, provided that you continue to timely pay your required employee contributions. While you are on paid status, your employee contribution will be deducted from your paycheck, provided that you have sufficient funds available after required deductions. If your employee contribution exceeds the amount of pay available, or if you are on unpaid status, you will receive a bill from Chevron's HR Service Center for your health plan coverage.

It is your responsibility to make timely payments for your regular benefits coverage as defined by the administrative rules of the Omnibus Health Care Plan. If the full premium payment is not received by the payment due date, your regular benefits coverage will be terminated retroactive to the end of the month for which full payment was received. If you have been on Military Service Leave for less than 24 months at the time your regular coverage ends, you will be offered continuation coverage (under USERRA).

Your, your spouse's or your dependent's period of continuation coverage under USERRA will begin on the date your Military Service Leave begins and will end on the earliest of the following dates:

- The 24-month period beginning on the date on which your Military Service Leave begins.
- The period ending on the day after the date on which you fail to timely apply for or return to a position of employment with Chevron, as determined under section 4312(e) of USERRA.

Periods of continuation coverage offered in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) will run concurrently with periods of continuation coverage offered pursuant to COBRA and Chevron policy.

You are covered under USERRA if you serve voluntarily or involuntarily as a member of the uniformed services of the United States, including serving in the reserves or as designated by the president. The uniformed services include the U.S. Army, Navy, Marines, Air Force and Coast Guard, and the Public Health Service Commissioned Corps.

How Much USERRA Continuation Coverage Costs

If you fail to pay your employee contributions such that you are no longer eligible for regular coverage and you elect USERRA continuation coverage, you must pay 100 percent, plus a 2 percent administrative fee, of the cost of health plan coverage that's continued. The cost of coverage will vary based on the plans you're enrolled in and how many family members are enrolled.

how to file a claim for eligibility

This section describes how to dispute decisions regarding your eligibility to participate in Chevron's health plans or for credit for health and welfare eligibility service.

If you have a question regarding your eligibility to participate in the Omnibus Health Care Plan or if you believe you are entitled to credit for health and welfare eligibility service, contact the HR Service Center. If you are not satisfied with the outcome, you can file a claim by following the procedures described below.

If you have been denied participation or if you believe you are entitled to credit for health and welfare eligibility service in the Omnibus Health Care Plan, you can file a written claim with the plan administrator. Include the grounds on which your claim is based and any documents, records, written comments or other information you feel will support the claim. Address your written correspondence to:

Chevron Corporation
Omnibus Health Care Plan Administrator
Chevron Human Resources Service Center
P.O. Box 199708
Dallas, TX 75219-9708

If you file a claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan, the plan administrator will send you a decision on the claim within 90 days after the claim is received. However, if there are special circumstances that require additional time, the plan administrator will advise you that additional time is needed and then will send you a decision within 180 days after the claim is received.

If the claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan is denied (in whole or in part), the plan administrator will send you a written explanation that includes:

- Specific reasons for the denial, as well as the specific Omnibus Health Care Plan provisions or Chevron policy on which the denial is based.
- A description of any additional information that could help you complete the claim, and reasons why the information is needed.
- Information about how you can appeal the denial of the claim.
- A statement explaining your right to file a civil lawsuit under section 502(a) of ERISA if your appeal is denied.

Appeals Procedures for Denied Claims Regarding Eligibility to Participate or Credit for Health and Welfare Eligibility Service in the Omnibus Health Care Plan

If your claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan is denied, in whole or in part, and you want to appeal the denial, you must file an appeal within 90 days after you receive written notice of the denial of your claim.

The appeal must be in writing, must describe all of the grounds on which it is based and should include any documents, records, written comments or other information you feel will support the appeal. Before submitting the appeal, you can review and receive, at no charge, copies of Omnibus Health Care Plan documents, records and other information relevant to your claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan.

The Review Panel will provide you with a written response to the appeal and will either reverse the earlier decision and permit participation, or provide credit for health and welfare eligibility service in the Omnibus Health Care Plan, or it will deny the appeal. If the appeal is denied, the written response will contain:

- The specific reasons for the denial and the specific Omnibus Health Care Plan provisions or Chevron policy on which the denial is based.

- Information explaining your right to review and receive, at no charge, copies of Omnibus Health Care Plan documents, records and other information relevant to your claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan.

- A statement explaining your right to file a civil lawsuit under section 502(a) of ERISA.

The Review Panel doesn't have the authority to change Omnibus Health Care Plan provisions or Chevron policy or to grant exceptions to the Omnibus Health Care Plan rules or Chevron policy.

For appeals regarding participation or credit for health and welfare eligibility service in the Omnibus Health Care Plan, address your written correspondence to:

Review Panel
Omnibus Health Care Plan
P.O. Box 6075
San Ramon, CA 94583-0775

The Review Panel may require you to submit (at your expense) additional information, documents or other material that it believes is necessary for the review.

You will be notified of the final determination of the appeal within 60 days after the date it's received, unless there are special circumstances that require additional time. You will be advised if more time is needed, and you'll then receive the final determination within 120 days after the appeal is received. If you do not receive a written decision within 60 or 120 days (whichever applies), you can take legal action.

glossary

Here are some important terms related to the plan(s) discussed in this book.

After-Tax Contributions
After-tax contributions are withheld from your paycheck after federal and state income taxes are withheld.

Allowable Charge
To be considered *allowable*, an out-of-network charge in the U.S. must be within a range of charges billed by doctors or other providers for the same service or supply. Allowable charges may vary from one geographic area to another. The plan's claims administrator determines if a charge is allowable. Allowable charges are determined by the claims administrators (other than charges for vision care covered under the plan's vision program or outpatient prescription drugs covered under the plan's Prescription Drug Program.

The discounted rates charged by providers in the PPO network aren't subject to the allowable charge provisions of the plan.

When reviewing charges to determine if they're covered under the plan, the plan's claims administrator doesn't attempt to set the amount that doctors and other providers charge for needed services, nor does the claims administrator restrict your right to go to any doctor you choose.

Before-Tax Contributions
Before-tax contributions are withheld from your pay first, before taxes are calculated and deducted. So you pay less in taxes. Before-tax contributions aren't subject to federal income taxes, and they aren't subject to state income taxes except in New Jersey and for some certain benefits, Pennsylvania. Also (unlike before-tax contributions to 401(k) savings plans), before-tax contributions to health plans, the Health Care Spending Account (HCSA) and the Dependent Day Care Spending Account (DCSA) aren't subject to Social Security taxes.

Before-Tax Contribution Plan
This is a plan that permits you to pay your portion of the monthly costs of any medical, dental, and vision plan coverage with before-tax contributions. If you choose before-tax deductions, you are automatically enrolled in the Before-Tax Contribution Plan. With this plan you are limited in your ability to make enrollment changes in your health plans during the year. Also, if you make contributions on a before-tax basis for medical coverage, you are required to make contributions on a before-tax basis for dental and vision coverage and vice versa.

Brand-Name Drug
Prescription Drug Program (Drugs Obtained Inside the U.S.)
A prescription drug that is all of the following:

- Manufactured and marketed under a trademark or a name given by a specific drug manufacturer.
- Typically protected under patent rights.
- Commonly acknowledged by pharmacies, drug companies and drug manufacturers as a brand-name drug.

Cigna
Cigna insures the health care benefits provided by the Global Choice Plan, which includes inpatient prescription drugs and outpatient prescription drugs obtained outside the U.S. Cigna or its delegate reviews, approves (or denies) and processes all claims (other than claims for outpatient prescription drugs purchased in the U.S. and vision care). In addition, their staff informs plan members which charges are covered and which aren't under the plan. If you have a question about a claim or if you need to speak with a customer service representative, call Cigna at Toll free: 1-800-828-5822 or Direct (collect calls accepted): 001-302-797-3871. For a list of network providers in the U.S., you can log on to the website at **www.cignaenvoy.com.**

CignaLinks
CignaLinks is a systematic integration of the global health care program with local administrators (and/or insurers). CignaLinks is currently available in Africa (South Africa, Tanzania, Kenya, Morocco, Egypt, and Nigeria), Australia, Brazil, China, Hong Kong, Indonesia, Macau, Malaysia, the Middle East (Saudi Arabia, United Arab Emirates, Kuwait, Bahrain, Oman, and Qatar), Singapore, Spain, Taiwan, and the United Kingdom. CignaLinks arrangements require a separate ID card, which employees who work or live in these countries will receive upon enrollment.

Casual Employee
An employee who's hired for a job that's expected to last no more than four months and who isn't designated by Chevron as a seasonal employee.

Coinsurance
A way you share costs of services with the plan. You and the plan split the costs by each paying a specified percentage of covered charges.

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

Company
Chevron Corporation and those of its subsidiaries that it has designated to participate in the Omnibus Health Care Plan and that have accepted such designation by appropriate corporate action. Such designation may include a limitation as to the classes or groups of employees of such subsidiary that may participate in the Omnibus Health Care Plan.

Copayment
A flat-rate charge you pay for office visits or services at the time services are delivered.

Corporation
Refers to Chevron Corporation.

Covered Charges
Applies only to medical coverage. Refer to Section 12 of the Cigna Certificate of Coverage.

Doctor
The term *doctor* means a doctor or surgeon (M.D.), a psychiatrist (M.D.), an osteopath (D.O.), a podiatrist (D.P.M.), a dentist (D.M.D. or D.D.S.), a chiropractor (D.C.) and an ophthalmologist (O.D.).

For care to be covered under the plans, the doctor must be licensed by the proper authorities of the state in which he or she practices, and practice and treatment must be within the scope of the doctor's license.

Former Atlas Employee
A person who otherwise qualifies as an eligible employee and who was employed by Atlas immediately prior to its merger with Chevron Corporation (or was employed by Chevron Northeast Upstream Corporation after the merger and on or before October 1, 2011) and who has not been terminated and rehired by Chevron or its affiliates.

Former Caltex Employee
A person who otherwise qualifies as an eligible employee and who was employed by Caltex immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron or its affiliates.

Former Chevron Employee
A person who otherwise qualifies as an eligible employee and who was employed by Chevron immediately prior to its merger with Texaco Inc. and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

Former Texaco Employee
A person who otherwise qualifies as an eligible employee and who was employed by Texaco Inc. immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

Former Unocal Employee
A person who otherwise qualifies as an eligible employee and who was employed by Unocal immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron since the merger with Unocal.

Generic Drug
Prescription Drug Program (Drugs Obtained Inside the U.S.)
A chemical copy of a brand-name prescription drug. Generic medications contain the same active ingredients and must be equivalent in strength and dosage to their brand-name counterparts. They are subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength and purity as their brand-name counterparts. Generally, generic drugs cost less than brand-name drugs. Some generics look different from the brand-name version of the drug because they contain different inactive ingredients. Inactive ingredients are, for example, additives that are used to keep a tablet from crumbling, to add bulk to a tablet, or to change a tablet's color or shape. Generic drugs typically cost 30 percent to 60 percent less than their brand-name counterparts because manufacturers of generic drugs don't have to pay for research and development or marketing and advertising.

Health and Welfare Eligibility Service

Your health and welfare eligibility service is used to determine your eligibility for vacation, service awards, Short-Term and Long-Term Disability plans and retiree health care benefits. The following applies to an individual who is an employee on or after January 1, 2012. Different rules apply to an individual who terminated employment prior to January 1, 2012.

Health and welfare eligibility service is generally the period of time you're employed by Chevron or by any other member of the Chevron affiliated group, and may include periods when you're not an eligible employee for U.S. pay and benefits.

Health and welfare eligibility service includes all the time you are on an approved Disability Leave for which you are receiving benefits under the Chevron Long-Term Disability Plan. Under special rules, it may also include the time you are on certain other approved leaves of absence. Special rules apply if you do not timely return to active work with a participating company or if you terminate your employment while on an approved leave of absence. Health and welfare eligibility service may also include the time you have been providing services as a “leased employee” on or after July 1, 2002 to a member of the Chevron affiliated group (at the time the services are performed) and you become an employee after providing service as a leased employee, as determined by Chevron in its sole discretion. If you believe one of these special rules apply to you, contact the HR Service Center for further information.

If you leave Chevron after July 1, 2002, and are rehired within 365 days, your service will include the time you were away. If you’re gone longer than 365 days and you haven’t had a permanent service break as a result of your absence, your service before you left will be added to your service after you’re rehired.

If you left Chevron and were rehired, your service before you left will be added to your service after you’re rehired unless you incurred a Permanent Service Break. If you have service with an acquired company prior to the date of the acquisition of that company by Chevron, special rules may apply — contact the HRSC for more information.

Note on grandfathering rules: The definition of health and welfare service has changed over time, and sometimes it has changed to include additional service that was not previously included. This will not change whether you are subject to a grandfather rule in effect prior to the change. This is because whether an employee meets the conditions to have a grandfather rule apply is determined under the rules in place as of the time the grandfather rule was effective.

HIPAA

The Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Hospital

A hospital must meet one of the following requirements:

- A legally constituted and operated institution having, on its premises, organized facilities (including diagnostic and major surgical facilities) for the care and treatment of sick and injured people. Care must be supervised by a staff of legally qualified doctors, and there must be a registered nurse (R.N.) on duty at all times.

- A free-standing rehabilitative facility that meets all of the following criteria:

  - Has a provider agreement, as required by Medicare.
  - Serves an inpatient population, with at least 75 percent of patients needing intensive rehabilitative services for the treatment of a stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of the femur, brain injury, polyarthritis, neurological disorders and burns.
  - Has a preadmission screening procedure to determine whether the patient would benefit from an intensive inpatient hospital program.
  - Ensures that patients receive close medical supervision and furnishes rehabilitation nursing, physical therapy and occupational therapy by qualified personnel.
  - Has a director of rehabilitation who is a doctor.
  - Establishes a plan of treatment for every patient that is reviewed as needed by a doctor who consults with other qualified personnel.
  - Uses a coordinated team approach to rehabilitate each patient.

The term *hospital* doesn't include any of the following facilities:

- Any institution used primarily as a rest or nursing facility.

- Any facility solely for use by the aged or the chronically ill or alcoholics.

- Any facility providing primarily educational or custodial care.

Incapacitated Child

An incapacitated child is a dependent child who is:

- Incapable of self-sustaining employment by reason of mental retardation or a mental or physical disability (proof of which must be medically certified by a physician).

- Dependent on you, you and your spouse/domestic partner or your surviving spouse/domestic partner who is covered under the plan, for more than one-half of his or her financial support.

- Your or your spouse/domestic partner's qualifying child under Section 152 of the Internal Revenue Code. This means that during the calendar year the individual 1) is your child, brother, sister stepbrother, stepsister or a descendent of such person; 2) lives with you for more than one-half the year and 3) does not provide over one-half of his or her own support.

The dependent child must be incapacitated under one of the following conditions:

- Immediately before turning age 26 while being covered under a Chevron health care plan.
- Before turning age 26 if he or she had other health care coverage immediately before you became an eligible employee and is enrolled in a Chevron health care plan within 31 days after you become an eligible employee.
- Before turning age 26 if he or she had other health care coverage immediately before the dependent child was enrolled in a Chevron health care plan.

When the child reaches age 26, and periodically thereafter, Chevron Corporation will require you to provide documentation stating that the child continues to be incapacitated. For chronic disabilities, as determined by the medical administrator, you must provide documentation every two years. If the disability is not chronic, the medical administrator will determine how frequently you will need to provide such documentation. For details, contact the HR Service Center.

Leased Employee

Someone who provides services to Chevron in a capacity other than that of a common-law employee and who meets the requirements of section 414(n) of the Internal Revenue Code. This law requires Chevron to treat leased employees as if they're common-law employees for some purposes, but doesn't require that they be eligible for benefits.

Maintenance Medication
Prescription Drug Program (Drugs Obtained Inside the U.S.)

Medication taken over an extended period of time (90 days or more) for the treatment of a chronic condition, such as diabetes, arthritis, ulcers, high blood pressure or heart conditions.

Managed Prior Authorization

The Express Scripts program that requires certain drugs to be approved by Express Scripts before the drug is dispensed in order for the drug to quality as a covered charge.

Medical Channel Management

The Express Scripts program aimed at identifying opportunities for shifting drug utilization from the medical channel to the pharmacy channel with respect to specialty drugs.

Multi-Source Drug

A medication that is available from multiple manufacturers and can include Brand-Name and Generic drugs depending on patent status.

Network Pharmacy
Prescription Drug Program (Drugs Obtained Inside the U.S.)

Express Scripts, the administrator of the Prescription Drug Program's retail pharmacy program, has negotiated a discount agreement with more than 64,000 pharmacies across the U.S. These pharmacies make up a network that includes pharmacy chains, pharmacies at discount stores, pharmacies at local and national grocery chains and many independent pharmacies. For participating pharmacies near you, visit **www.Express-Scripts.com** or call Express Scripts Member Services at 1-800-987-8368.

Network Price (Prescription Drug Program)
Drugs Obtained Inside the U.S.
A discounted price charged for a prescription when a network pharmacy is used.

Nonpreferred Brand-Name Drugs (Prescription Drug Program)
Drugs Obtained Inside the U.S.
Drugs that are covered by the Prescription Drug Program, which receive a lower level of reimbursement compared with preferred brand-name drugs. These drugs are not on Express Scripts' list of preferred brand-name drugs.

Nurse
A registered nurse (R.N.), licensed vocational nurse (L.V.N.) or licensed practical nurse (L.P.N.).

Open Enrollment
Typically, open enrollment is held annually during a two-week period each fall. During open enrollment, you can make changes to your benefit elections and such changes will take effect the following January 1.

Out-of-Pocket Maximum
After you pay your deductible, the plan pays a percentage of covered charges for the care you need and you pay any costs above the amount paid by the plan.

After your out-of-pocket costs reach the specified amount for the coverage tier, the plan pays 100 percent of all covered charges until the end of the calendar year.

Outpatient Care
Care provided without an overnight stay in a hospital.

Outpatient Prescription Drugs
Prescription Drug Program (Drugs Obtained Inside the U.S.)
Drugs that are dispensed by a retail or home delivery pharmacy (excluding drugs dispensed at hospitals, doctors' offices or skilled nursing facilities).

Payroll
The system used by Chevron to withhold employment taxes and pay its common-law employees. The term doesn't include any system to pay workers whom Chevron doesn't consider to be common-law employees and for whom employment taxes aren't withheld, such as workers Chevron regards as independent contractors or common-law employees of independent contractors.

Permanent Service Break (for health and welfare eligibility service)
You will not have a permanent service break if you leave Chevron with more than five years of health and welfare eligibility service. You will, however, have a permanent service break if you leave Chevron before you have five years of health and welfare eligibility service and you're not rehired within five years. If you left Chevron before July 1, 2002 and are not an eligible employee at any time on or after January 1, 2012, applicable rules at the time of your termination will apply to whether you had a permanent service break.

Preferred Brand-Name Drugs
Prescription Drug Program (Drugs Obtained Inside the U.S.)

Drugs that are covered by the Prescription Drug Program and receive a higher level of reimbursement compared with nonpreferred drugs. The list of preferred brand-name drugs (sometimes called a formulary list) includes commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings. Preferred brand-name drugs receive a higher level of reimbursement compared with nonpreferred brand-name drugs. For updated formulary information, visit **www.Express-Scripts.com** or call Express Scripts Member Services at 1-800-987-8368.

Primary Payer

The plan that pays benefits first.

Professional Intern

An individual who works either a full-time or part-time work schedule and whose work periods with Chevron alternate with school periods.

Provider

A hospital, medical or health care facility, doctor, dentist or other health professional licensed where required, performing within the scope of that license.

- A participating provider or network provider has agreed to charge discounted rates for services provided to plan members. To encourage you to use these providers, the plan often pays a higher benefit rate for network services. Also, you generally don't have to file a claim form when you go to a network provider. You can obtain a list of network providers in your area by contacting your claims administrator.

- A nonparticipating or out-of-network provider does not have an agreement with the claims administrator pertaining to the payment of covered services for a member.

Regular Work Schedule

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

Rotational Expatriate Assignment

Chevron has operations in locations where no adequate resources are available to provide the necessary infrastructure and support for expatriate families to reside. Elsewhere, particular circumstances (for example, climate, remote location, and security) render the location unsuited for family living. In those circumstances, expatriate assignments are administered under the Rotational Expatriate Assignment policy. Under the terms of the policy, the family stays in the home location, and the employee commutes to the host-country work location, works a designated number of days in the host country during which room and board is provided, followed by an equal number of days off.

Seasonal Employee

An individual who's hired to work a regular work schedule for a portion of each year on a repetitive basis in a job designated to cover a seasonal operating need.

Secondary Payer

The plan that pays benefits second.

Single-Source Brand-Name Drugs
A Brand-Name Drug that doesn't have a generic equivalent and is only available from one manufacturer or source, typically the original company.

Specialty Drug
Prescription Drug Program (Drugs Obtained Inside the U.S.)
A prescription drug that Express Scripts has designated as a Specialty Drug. In general, Specialty Drugs are high-cost drugs that may be used to treat complex or rare medical conditions. Specialty Drugs are generally biotechnological in nature and may have special shipping, storage or handling requirements. Specialty Drugs often require injection or other non-oral methods of administration.

Some of the disease categories for which certain prescription drugs are currently designated as Specialty Drugs by Express Scripts's include cancer, cystic fibrosis, Gaucher disease, growth hormone deficiency, hemophilia, immune deficiency, Hepatitis C, infertility, multiple sclerosis, rheumatoid arthritis, and RSV prophylaxis. Express Scripts may add or delete drugs from the Specialty category as new treatments become available.

For information on whether a particular drug is a Specialty Drug, or whether it is subject to the home delivery requirement for maintenance Specialty Drug refills, contact Express Scripts at 1-800-987-8368.

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

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

VSP (Vision Service Plan) Vision Care
VSP is the insurer for the vision benefits you receive through the Medical PPO and also the Vision Plus program. VSP manages the plan's preferred provider organization and processes claims filed by you or your provider. VSP can be reached by telephone at 1-800-877-7195 Monday through Friday from 5 a.m. to 7 p.m. Pacific time, on Saturday from 7 a.m. to 8 p.m. Pacific time and on Sunday from 7 a.m. to 7pm Pacific time. If you're outside the U.S. and unable to access the toll-free number you may contact VSP by telephone at (916) 851-5000 (press "0" for operator assistance) Monday through Friday from 7 a.m. to 5 p.m. Pacific time. Or you can access the VSP's website at **www.vsp.com/go/chevron**.