health benefits for expatriates in the U.S.

summary plan description (SPD)
effective january 1, 2017

This summary plan description describes the health plans as of January 1, 2017, that Chevron sponsors for eligible expatriates working in the U.S. This information constitutes the summary plan description (SPD) as required by the Employee Retirement Income Security Act of 1974 (ERISA) for the following health plans:

- Global Choice Plan (Expatriates in the U.S.) which includes medical, prescription drug and basic vision coverage.
- Chevron Dental Plan (also referred to as the Dental PPO).
- Mental Health and Substance Use Disorder Plan, as it applies to expatriates working in the U.S.

If you are not an expatriate working in the U.S. or an eligible dependent of an expatriate working in the U.S., then these descriptions do not apply to you.

These descriptions don't cover every provision of the plans. 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.

Resident U.S.-payroll expatriates should go to **hr2.chevron.com** to review the summary plan descriptions for the Global Choice Plan (U.S.-Payroll Expatriates) and other benefits that apply to you.

update to addresses
for benefits correspondence
effective June 1, 2020

human energy. yours.™

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

travel reimbursement
for covered services

mental health and substance use disorder plan
effective august 1, 2022

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

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

overview

Effective August 1, 2022, the Mental Health and Substance Use Disorder (MHSUD) Plan now also includes an expanded travel expense reimbursement benefit for all covered services if you cannot access the care you need where you live. The benefit applies to a covered service received on or after August 1, 2022, and for travel to obtain that service on or after August 1, 2022.

how it works

This plan provision reimburses you for charges incurred for reasonable, qualifying travel expenses that are essential to receive any covered service under the **Chevron Mental Health and Substance Use Disorder (MHSUD) Plan** for **U.S.-payroll employees** and **expatriates on assignment in the U.S.** To be eligible for reimbursement, *all* of the following requirements must be satisfied:

- **The covered service is not reasonably available to you from a network provider or facility within 100 miles of your home residence.**
  Reasonably available might include – but is not limited to – when there are no network providers or facilities who offer the service in your area, or you cannot get an appointment within a reasonable time based on your behavioral health situation.

- **The behavioral health care must be a covered service under the MHSUD.**
  - If the related service is not covered or benefits are denied, travel expenses will not be covered.
  - Note that this benefit only provides reimbursement for qualifying travel expenses; the cost of the covered service continues to be covered as per the plan's normal schedule of behavioral health benefits and is separate from this travel benefit plan provision.
  - Travel expense reimbursements for online visits are also ineligible for reimbursement under this plan provision because this service can be accessed without the requirement to travel.

- **The expense must be a covered, qualifying travel expense.**
  In general, qualifying travel expenses for non-emergency transportation and/or lodging must be essential to obtain a covered service and are incurred by an enrolled participant (the patient) and caregiver, if any. See the *Qualifying Travel Expenses* section below for further details.

- **The qualifying expenses are incurred by the plan participant receiving the covered service - the patient - and eligible caregiver(s), if any.**
  To receive reimbursement for qualifying travel expenses, an eligible *caregiver* must meet **both** of the following requirements:
  - The caregiver is a person who can give injections, medications, or other treatment required by the patient who is unable to travel alone to receive the covered service.
  - The caregiver(s) must travel with the patient on the same day(s) to and from the site where the service is provided.

  If the patient is a dependent child enrolled in the MHSUD, the qualifying travel expenses of up to **two** caregivers will be covered – a parent who must accompany the child and another caregiver. For adult patients, qualifying travel expenses for **one** caregiver will be covered.

- **Reimbursement is subject to IRS and plan reimbursement limits.**
  You are limited in the amount of reimbursement you can receive for qualifying travel expenses. Amounts in excess of any applicable limits will not be reimbursed. See the *Reimbursement Limits* section below for further details.

- **Reimbursement may be subject to the annual deductible, depending on your medical coverage.**
  - For MHSUD participants enrolled in the Medical PPO Plan, a Medical HMO, Global Choice or waiving Chevron medical coverage, qualifying travel expenses *are not* subject to the deductible.
  - For MHSUD participants enrolled in the High Deductible Health Plan or the High Deductible Health Plan Basic, there is one combined deductible for medical, prescription drugs, mental health and substance use disorder services. Qualifying travel expenses *are* subject to the applicable annual combined deductible.
  - As a reminder, benefits for the covered behavioral health service will continue to follow the MHSUD's normal deductible, coinsurance or copayment schedule.

- **The covered service must be received in the United States*, from either a network or out-of-network provider or facility.**
  While you are strongly encouraged to use a network provider or facility whenever possible, there is no network requirement to receive reimbursement under this plan provision.
  ** Includes a territory or possession under the jurisdiction of the United States.*

- **Properly completed travel claim(s) for reimbursement, including documentation, are submitted by the plan's claim filing deadline.**
  Submit your travel benefit claim as soon as possible after your related behavioral health claim is approved. You must file a claim for reimbursement of travel expenses no later than six months (by June 30) following the calendar year in which the covered service was provided. If you don't file a proper claim within this time frame, travel expenses for the related covered service will be denied. Refer to the MHSUD summary plan description for more information about claim filing limitations and exclusions. See the *How to Use the Travel Benefit* section later in this document for further instructions about the travel claim process.

qualifying travel expenses

For purposes of this plan provision, qualifying travel expenses are generally non-emergency **Lodging** and **Transportation** expenses for which you could have claimed a medical tax deduction on an itemized federal income tax return. Guidance for what constitutes such an expense may be found in **IRS Publication 502 – Medical and Dental Expenses**. In general, qualifying transportation and/or lodging expenses must be essential to obtain a covered service and are incurred by an enrolled participant (the patient) and caregiver, if any.

General examples of **qualifying travel expenses** include but are not limited to:

- Mileage in your personal car to/from your home to the covered service provider or facility
- Rental cars
- Train or airline travel tickets
- Bus, shuttle, taxi and ride share services
- Lodging not provided by a hospital or other institution for the patient and caregiver, subject to IRS per diem limits
- Gas
- Tolls
- Long-term airport parking or other parking fees

Qualifying travel expenses do not include meals, personal use items (laundry, telephone calls, vehicle maintenance, etc.) or other travel expenses that relate to travel that is merely beneficial to general health and unrelated to a covered service, such as a vacation or personal trip. They also don't include amounts you pay for the care of children, even if the expenses enable you, your spouse or domestic partner, or your dependent to receive a covered service.

Review IRS Publication 502 available online at www.irs.gov for complete details about what are and are not qualifying expenses.

reimbursement limits

Under this provision, you are limited in the amount of reimbursement you can receive for qualifying transportation and lodging expenses. Amounts in excess of any applicable limits will not be reimbursed. Reimbursement is subject to the following limits:

- **$2,000 per covered service maximum** – whether the related behavioral health service is received from a network or out-of-network provider or facility – for qualifying transportation and lodging expenses incurred by the plan participant receiving the covered service (the patient) and the eligible caregiver(s).
- A combined **overall lifetime maximum of $10,000** per covered plan participant when traveling as the patient receiving the covered service.
  - The same limit applies whether the related behavioral health service is received from a network or out-of-network provider or facility.
  - The limit applies to qualifying transportation and lodging expenses incurred by the patient and the eligible caregiver(s), combined.
  - This lifetime maximum benefit aggregates the qualifying travel expense reimbursements accumulated while you're an eligible participant in the Chevron Medical PPO Plan, the Chevron High Deductible Health Plan (HDHP), the High Deductible Health Plan Basic (HDHP Basic), the Mental Health and Substance Use Disorder (MHSUD) Plan, or any combination thereof.
- Qualifying charges for reasonable and necessary **lodging expenses** for the patient (while not confined) and caregiver are *also* subject to the current IRS per diem limit, as defined in Publication 502. As of the writing of this publication, those limits are as follows:
  - For covered adult patients, the per diem rate is up to **$50** for one person or up to **$100** per day for a patient and one caregiver, combined.
  - If the patient is a covered dependent minor child, the transportation expenses of two caregivers will be covered, but lodging will be reimbursed up to the **$100** per diem rate for the patient and both caregivers, combined.

how to use the travel benefit

Follow these steps to request reimbursement for qualifying travel expenses under this plan provision.

Step 1: Plan ahead, when possible

- Be sure to read these plan rules for the travel benefit to ensure you are meeting all requirements to be eligible for reimbursement. If you have questions, contact Beacon Health Options.
- Remember that the health service you or an enrolled dependent receives must be a *covered service* under the MHSUD. If your coverage for the service is denied, you cannot request reimbursement for travel expenses. **For this reason, you are strongly encouraged to contact Beacon Health Options in advance, when possible, to confirm coverage for the service** and ensure you have completed any other plan requirements necessary to receive that coverage.
- You do not need to receive pre-approval to use the *travel* benefit, but if your covered behavioral health service requires prior authorization, you will need to complete these normal benefit requirements to receive coverage for the service. If the behavioral health service isn't covered, your travel expenses aren't covered.
- You'll need to make your own travel and lodging arrangements.
- Beacon Health Options can help you locate a network provider or facility. You can choose any provider or facility but using a network provider or facility can save you money on your out-of-pocket costs for the behavioral health service.
- Keep in mind that you can't be reimbursed for qualifying travel expenses in *advance* of receiving the behavioral health service, even if you've prepaid for air or train tickets and lodging.
- You are responsible for the payment of services rendered. Beacon Health Options will reimburse you directly, not the transportation or lodging provider.

Step 2: Receive care, save your receipts

When you submit a claim for reimbursement of qualifying travel expenses, you will be required to provide a valid receipt for all transportation and/or lodging expenses. Be sure that your receipts are itemized and legible. Itemization includes, but is not limited to: name, date, time, amounts, and purpose. Credit card statements are not acceptable as documentation, so be sure to collect proper documentation at each step of your journey. You should also make a copy of all receipts and itemized bills as originals will not be returned to you.

Step 3: Submit a *behavioral health* claim for the covered service, first

The related qualifying behavioral health claim for the covered service must be on file with and approved by Beacon Health Options *before* you can submit a claim for reimbursement of travel expenses. As a reminder, if the service was received from a network provider or facility, the provider or facility will file a behavioral health claim for you. If the service was received from an out-of-network provider or facility, it is your responsibility to file a claim with Beacon Health Options. You can file a claim or check the status of a behavioral health claim:

- Download the form on the **Forms Library** at **hr2.chevron.com**.
- Call Beacon Health Options at **1-800-847-2438** (714-763-2420 outside the U.S.)

Step 4: Submit a travel claim for the travel expenses, last

You can submit a claim for reimbursement of qualifying travel expenses after Beacon Health Options has approved your claim for the related behavioral health service. *Do not* use the standard behavioral health claim form or the Beacon Health Options website to submit a travel benefit claim. You must use the **MHSUD Claim for Reimbursement of Travel Expenses** paper form *specifically* for this reimbursement. Complete submission instructions are included on the form. Your reimbursement will be paid from Beacon Health Options after processing. You can get the special travel benefit claim form:

- From the **Forms Library** on **hr2.chevron.com**.

As a reminder, your signature on the **MHSUD Claim for Reimbursement of Travel Expenses** form attests to the accuracy and completeness of all information on the form, including the receipts, and that you acknowledge that any material omission or misrepresentation of facts may result in the denial of benefits, termination of coverage for you and your dependents and/or disciplinary action including and up to termination of employment. It also authorizes the release of your health records by the provider to Beacon Health Options, if necessary.

contact

Contact **Beacon Health Options** directly at **1-800-847-2438 (714-763-2420 outside the U.S.)** to discuss claims, coverage under your plan, or to find a network provider.

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.

(Continued next page.)

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**

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 and welfare plans or any company contributions towards the cost of such health and welfare plans. Rather, Chevron Corporation reserves all rights, for any reason and at any time, to amend, change or terminate these plans or to change or eliminate the company contribution toward the cost of such plans. Such amendments, changes, terminations, or eliminations may be applicable without regard to whether someone previously terminated employment with Chevron or previously was subject to a grandfathering provision. Some benefit plans and policies described in this document may be subject to collective bargaining and, therefore, may not apply to union-represented employees.

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.

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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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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.

rare conditions program
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.

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**.

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

human energy. yours.™

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

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**.

legal guardian clarification
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.

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**.

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

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.

dependent verification requirement 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.

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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.

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.

new qualifying life event

health plans

effective January 1, 2019

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

The enclosed information serves as an official summary of material modification (SMM) for all Chevron medical plans including the **Medical PPO Plan, High Deductible Health Plan, High Deductible Health Plan Basic,** all **Medical HMO Plans,** and the **Global Choice Plan (U.S.-Payroll Expatriate)**. Please keep this information with your other plan documents for future reference. You can access the summary plan descriptions for your benefits at **hr2.chevron.com / hr2.chevron.com/retiree** or by calling the HR Service Center at **1-888-825-5247**.

new qualifying life event

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

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

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

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

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

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new fee for insufficient funds

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 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.

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.

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prescription drug program

for prescription drugs obtained inside the United States or through mail-order

Prescription drug coverage is automatically provided as part of your Global Choice Plan (Expatriates in the U.S.). **Cigna** is the insurer for prescription drugs obtained *outside* the United States. There are no changes to your Cigna prescription drug coverage for 2019. **Express Scripts** is the insurer for the Prescription Drug Program which covers prescription drugs obtained inside the United States and through mail order within the United States. This section describes changes to the 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 Global Choice Plan (Expatriates in the U.S.), 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.

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.

have questions?

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

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**.

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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**

advance notification and pre-certification update

mental health and substance use disorder plan

effective January 1, 2021

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

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

advance notification and pre-certification update

for electroconvulsive therapy and psychological testing

The **Mental Health and Substance Use Disorder (MHSUD) Plan** covers psychological testing and electroconvulsive therapy when used to diagnose a mental health disorder or when provided in conjunction with a diagnosed/covered psychiatric disorder. Psychological testing for learning disabilities is not covered.

Under current plan rules, for psychological testing and electroconvulsive therapy to be covered, advance notification to Beacon Health Options and pre-certification is required, and services must be medically necessary and appropriate in order to receive the full benefits under the MHSA Plan.

Effective January 1, 2021, the requirement for advance notification to and pre-certification by Beacon Health Options for psychological testing and electroconvulsive therapy is eliminated. However, these services must be medically necessary and appropriate in order to receive the full benefits under the MHSA Plan.

contact

Consult the MHSUD Plan summary plan description or contact **Beacon Health Options** directly at **1-800-847-2438** for more information or for further instructions about psychological testing and electroconvulsive therapy.

online visits
non- MDLIVE provider coverage
mental health and substance use disorder plan
effective January 1, 2021

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

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

online visits
non-MDLIVE provider coverage

Where state laws allow, telebehavioral health services through MDLIVE are available under the **Mental Health and Substance Use Disorder (MHSUD) Plan** to employees, retirees and covered dependents eligible to participate in the MHSUD Plan. To be covered, telebehavioral health services must be accessed through Beacon's Telehealth service with an MDLIVE provider via telephone and/or secure video.

We announced in March 2020 that telebehavioral health services would be *temporarily* extended to include visits from a non-MDLIVE provider. Chevron has decided this coverage is no longer temporary and, as of **January 1, 2021**, coverage for non-MDLIVE providers will continue.

Effective **January 1, 2021** the following additional rule applies to **telebehavioral health services** under the **MHSUD Plan**:

- Where state laws allow, the MHSUD Plan coverage rules for **telebehavioral health services** include telebehavioral health services **provided by a non-MDLIVE provider** via telephone and/or secure video.

All other rules and requirements for telebehavioral health services under the MHSUD Plan continue to apply unchanged, including:

- The MHSUD Plan's standard **deductible**, **coinsurance** or **copayment**, and **out-of-pocket maximum** plan rules and requirements are applied to your covered telebehavioral health services, as applicable.
- Telebehavioral health services are considered an outpatient treatment, so the MHSUD Plan's standard **Outpatient Office Visit** schedule of benefits will apply.

contact

Consult the MHSUD Plan summary plan description or contact **Beacon Health Options** directly at **1-800-847-2438** for more information or for further instructions about telebehavioral health coverage.

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telebehavioral health service

mental health and substance use disorder plan

effective march 18, 2020

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Update to the summary plan descriptions (SPD)
All changes described in this SMM are effective March 18, 2020 unless otherwise indicated.

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

telebehavioral health coverage temporarily extended to include non-MDLIVE providers

Effective March 2019, where state laws allow, telebehavioral health services through MDLIVE were made available under the **Mental Health and Substance Use Disorder (MHSUD) Plan** to employees, retirees and covered dependents eligible to participate in the plan. To be covered under the plan, telebehavioral health services must be accessed through Beacon's Telehealth service with an MDLIVE provider via telephone and/or secure video. Telebehavioral health service is not covered outside of the MDLIVE provider group.

In recognition of current physical distancing requirements and the heightened need for behavioral health care during the COVID-19 pandemic, effective **March 18, 2020** the following temporary rules apply under the **Mental Health and Substance Use Disorder (MHSUD) Plan**:

- The MHSUD Plan coverage rules for telebehavioral health services will be extended to include telebehavioral health services **provided by a non-MDLIVE provider** via telephone and/or secure video.
- This temporary extension for telebehavioral health services **provided by a non-MDLIVE provider** will be in effect beginning on March 18, 2020 until the end of the COVID-19 emergency period. As of this writing, the emergency period ends **June 16, 2020**, but is subject to change.

about telebehavioral health services

With confidential **telebehavioral health services**, you can use your laptop, tablet, or smartphone to visit with a counselor or psychiatrist from your home, office, or on-the-go. Counselors and prescribers are available by phone or secure video to address:

- Stress management
- Relationship issues
- Mental health conditions such as depression and anxiety
- Life changes
- Substance use disorders and other addictive behaviors
- And more

what's covered

To be covered under the MHSUD Plan, telebehavioral health services:

- Must be accessed through **Beacon's Telehealth service** with an **MDLIVE provider** via telephone and/or secure video. Telebehavioral health services do not include consultations *outside* of the MDLIVE service. MDLIVE is a provider group that is formally contracted as a group provider with Beacon Health Options.
    - Exception: As noted above, telebehavioral health services will be extended to include such services **provided by a non-MDLIVE provider** via telephone and/or secure video on or after March 18, 2020 until the end of the COVID-19 emergency period.
- Telebehavioral health services do not include email, text or fax consultations.
- Must be for a **covered condition** under the MHSUD Plan and be deemed medically appropriate by Beacon Health Options.
- Must be for a mental health and substance use disorder condition that Beacon has deemed **appropriate for treatment through telebehavorial health services**. Not all services, including the management of certain controlled medications, are appropriate for this type of remote treatment option.
- Must be allowed under **state law**.

Keep in mind that the MHSUD Plan's pre-certification and/or notification rules – if any – continue to apply depending on the type of service you receive. In addition, telehealth/telemedicine visits that occur within behavioral health facilities will not be covered.

cost of service

- The MHSUD Plan's standard **deductible**, **coinsurance** or **copayment**, and **out-of-pocket maximum** plan rules and requirements are applied to your covered telebehavioral health services, as applicable.
- Telebehavioral health services are considered an outpatient treatment, so the MHSUD Plan's standard **Outpatient Office Visit** schedule of benefits will apply.
- **No claim forms** or other filing with Beacon is needed when you use MDLIVE; the payment requested (if any) is your actual out-of-pocket cost for that service.
- The MHSUD Plan **doesn't cover prescription drugs** for outpatient treatment – whether you're visiting a provider in the office or through Beacon's telebehavioral health service. If you are prescribed a drug as part of your telebehavioral health service, you should check with your prescription drug plan administrator to find out if it can help pay for the drugs you need; otherwise, you'll be responsible for paying the full cost of prescribed outpatient medication.

When you call or access the **MDLIVE** secure website or app, you'll answer questions about yourself and the service you require, and you'll get to choose from a list of available providers. MDLIVE will use these answers and apply your MHSUD Plan rules to determine your personal out-of-pocket cost for that telebehavioral health visit. You'll see the cost for the visit, and you'll need to provide a valid form of payment prior to proceeding with your telebehavioral health visit.

how to use the MDLIVE service

To use telebehavioral health services:

- **Step One:** Register for an MDLIVE account.
- **Step Two:** Schedule a telehealth appointment from your MDLIVE account.
- **Step Three:** Access your MDLIVE account at your scheduled appointment time. Appointments can be done from your computer connected to the internet from the secure MDLIVE website, from your mobile device through the app, or by phone if necessary.

How to register your MDLIVE account

- To register for this service, you first need your **Beacon Member ID**. Beacon doesn't issue ID cards for this benefit, so call Beacon Health Options at **1-800-847-2438 (714-763-2420 outside the U.S., call collect)** to obtain your identification number.
- There are two ways to register, from the **MDLIVE website** or **by phone**.

Register from the MDLIVE website

- Go to **www.MDLIVE.com/chevron**.
- Have your **Beacon Member ID** ready.
- Answer questions when prompted, then set up a personalized MDLIVE account, including your own username and password.
- On the MDLIVE site you may then select your type of service, preview the cost for your telebehavioral health visit, search MDLIVE providers, and make appointments with MDLIVE telebehavioral health providers.

Register by phone

- Text **CHEVRON** (all capital letters) to the **Sophie AppBot** at **635-483** and answer the questions posed by the secure application. Have your **Beacon Member ID** ready.
- **Call MDLIVE** directly at **1-888-430-4827** and speak with an MDLIVE representative for help registering an account, selecting an eligible provider, or scheduling an MDLIVE appointment.

mental health and substance use disorder plan

effective january 1, 2020

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

official plan name change

Applies to the plan formerly known as the Mental Health and Substance Abuse (MHSA) Plan

Effective January 1, 2020 the official plan name for the Chevron Mental Health and Substance Abuse (MHSA) Plan will change to the **Chevron Mental Health and Substance Use Disorder (MHSUD) Plan**. This is a name change only; there is no change to the eligibility, plan design, or administrative practices under this plan because of the new name.

mental health and substance use disorder plan

effective january 1, 2020

human energy. yours.™

Update to the summary plan descriptions (SPD)
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transcranial magnetic stimulation (TMS)

Applies to the Mental Health and Substance Use Disorder (MHSUD) Plan

As a clarification of current covered services, the Mental Health and Substance Use Disorder (MHSUD) Plan covers **Transcranial Magnetic Stimulation (TMS)** when provided in conjunction with a diagnosed and covered psychiatric disorder. TMS services must meet medical necessity as determined by Beacon Health Options and pre-certification is required in order to receive full benefits provided by the MHSUD Plan.

Transcranial Magnetic Stimulation (TMS) is a noninvasive method of brain stimulation in which electromagnetic devices are used to induce a mild electrical current, typically used to assist patients suffering from treatment-resistant depression.

Consult the MHSUD Plan summary plan description or contact Beacon Health Options at 1-800-847-2438 for more information or for further instructions about how to obtain pre-certification.

Update to the Summary Plan Description
Effective March 1, 2019

All changes described in this SMM are effective March 1, 2019.

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You can access the summary plan descriptions for your benefits on the Internet at **hr2.chevron.com** or by calling the HR Service Center at 1-888-825-5247.

This SMM applies to the following summary plan description:

- **Chevron Mental Health and Substance Abuse (MHSA) Plan (Expatriates in the U.S.)**

Temporary Special Provision for Permian Basin Participants

Effective March 1, 2019, a temporary special provision will take effect under the **Chevron Mental Health and Substance Abuse (MHSA) Plan** for expatriates on an assignment in the U.S. who maintain a permanent home address in one any of the specified zip codes in the Permian Basin. This Summary of Material Modification (SMM) explains the temporary special provision, how it works, who's eligible for it, and additional considerations you should be aware of when it's applied.

What is the temporary special provision?

Under standard MHSA Plan rules, your out-of-pocket costs for covered services may be different depending on if you see a **network** or an **out-of-network provider**. In general, using a network provider saves you money.

However, under this temporary special provision, if you're an **eligible Permian participant** who receives covered **services** on or after **March 1, 2019** from an **out-of-network provider** located in one of the **specified zip codes**, the MHSA Plan's **network** coinsurance rates will *generally* be applied to the covered services received from the out-of-network provider.

Who is eligible

Eligible Permian participant

You're eligible for this temporary special provision if you're an Expatriate on assignment in the U.S. and considered an eligible Permian participant. An **eligible Permian participant** is an eligible employee, eligible retiree or covered eligible dependent who is:

- Eligible to participate in the MHSA Plan at the time covered services are received.
- Maintains a permanent home address in any one of the zip codes specified by the temporary special provision.

The current specified zip codes are included in this SMM.

If you move and your permanent home address is *no longer in* one of the specified zip codes, you are *not* an eligible Permian participant. This means the temporary special provision will no longer apply to covered services received on or after the effective date of your new permanent home address.

Eligible out-of-network provider

The temporary special provision only applies if you're an eligible Permian participant who receives covered services from an out-of-network provider located in any one of the zip codes specified by the temporary special provision. The current specified zip codes are included in this SMM.

The temporary special provision *does not apply* if you're an eligible Permian participant, but you receive covered services from an out-of-network provider who is *not* located in any of the specified zip codes. In these situations, the MHSA Plan's standard out-of-network rules and requirements will apply.

Network providers are only available inside the United States. The temporary special provision does not apply if you go to a provider outside the U.S.

How the special provision works

Under this temporary special provision, if you're an **eligible Permian participant** who receives covered services on or after **March 1, 2019** from an **out-of-network provider** located in one of the **specified zip codes**, the following rules will apply:

Deductible

- There is *no deductible* for the MHSA Plan – regardless if you receive covered services from a network or out-of-network provider. The temporary special provision doesn't change the standard MHSA Plan deductible rules.

Coinsurance

Under the MHSA Plan's *standard* coinsurance rules, the Plan generally pays 100 percent of covered services when you use a provider in the Beacon Health Options network inside the United States (also called a network provider). However, if you use a provider in the U.S. that is *not* in the Beacon Health Options network (also called an out-of-network provider), you'll have to share the cost of the covered services. The plan generally pays 70 percent of covered charges when you visit and out-of-network provider in the U.S. In addition, out-of-network plan benefits are based on **billed charges**, so you may be responsible costs in *excess* of the billed charges.

Under this temporary special provision, if you're an **eligible Permian participant** who receives covered services on or after **March 1, 2019** from an **out-of-network provider** located in one of the **specified zip codes**, the following coinsurance rules will apply:

- The MHSA Plan's **network coinsurance rates** will apply to the **billed charges** for covered mental health and substance use disorder services.
- This means the Plan will generally pay **100 percent** of **billed charges** for covered services received from an out-of-network provider. If your out-of-network provider charges *more* than the billed charge amount set by Beacon Health Options, you must pay the full cost of any charges in excess of the billed charge amount for that service.
- All other MHSA Plan rules and requirements will continue to apply, including the current requirements to notify Beacon Health Options and/or Chevron Employee Assistance Program (EAP) for specific services.

Annual out-of-pocket maximum

- There is one combined annual out-of-pocket maximum under the MHSA Plan – regardless if you receive covered services from a network or out-of-network provider.
- Remember, your eligible out-of-pocket Global Choice Plan (Expatriates in the U.S.) expenses are combined with your eligible out-of-pocket mental health and substance abuse disorder expenses under the MHSA Plan to determine if your out-of-pocket maximum has been reached.
- The temporary special provision doesn't change the standard MHSA Plan annual out-of-pocket rules.

What's not changing

The temporary special provision only affects how your MHSA Plan's coinsurance rules are applied for out-of-network covered mental health and substance use disorder services when an eligible Permian participant visits an out-of-network provider in one of the specified zip codes.

It does not:

- Alter the benefits provided by your MHSA Plan. The types of services the MHSA Plan covers remain the same.
- Alter the MHSA Plan's standard coinsurance rates for covered services from a network provider *or* an out-of-network provider who is *not* located in one of the specified zip codes.
- Alter the MHSA Plan's standard coinsurance rates for covered services from a provider outside the U.S.
- Alter the MHSA Plan's standard eligibility rules – who can enroll and who you can cover.

Filing a claim for services

While the temporary special provision applies certain network rules to out-of-network covered services received by an eligible Permian participant in one of the specified zip codes, you'll still generally need to submit a claim to Beacon Health Options to be reimbursed for covered services when you use an out-of-network provider. Contact Beacon at **1-800-847-2438 (714-763-2420 outside the U.S., call collect)** or log in to your account at **www.achievesolutions.net/chevron** to submit a claim.

Specified eligible zip codes
Temporary Special Provision for Permian participants
Effective January 1, 2021

76930	79511	79718	79758	79789	88250
76932	79512	79719	79759	79830	88252
76934	79517	79720	79760	79837	88253
76941	79527	79721	79761	79842	88254
76943	79532	79730	79762	79847	88255
76945	79535	79731	79763	79848	88256
76951	79545	79733	79764	79851	88260
76958	79549	79734	79765	79854	88262
78851	79550	79735	79766	79855	88263
79316	79565	79738	79768	88201	88264
79323	79701	79739	79769	88203	88265
79330	79702	79740	79770	88210	88267
79331	79703	79741	79772	88211	88268
79342	79704	79742	79776	88213	
79345	79705	79743	79777	88220	
79351	79706	79744	79778	88221	
79355	79707	79745	79780	88230	
79356	79708	79748	79781	88231	
79359	79710	79749	79782	88232	
79360	79711	79752	79783	88240	
79373	79712	79754	79785	88241	
79376	79713	79755	79786	88242	
79381	79714	79756	79788	88244	

applied behavior analysis (ABA) MHSUD

effective january 1, 2018

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chevron mental health and substance abuse (MHSA) plan

When autism-related disorders are suspected, early diagnosis and intervention can have a positive effect on your child and your family. That's why, effective January 1, 2018, the MHSA Plan will include coverage for **Applied Behavior Analysis (ABA)** treatment for those diagnosed with autism or pervasive development disorder (PDD). ABA includes many different techniques to increase useful or desired behaviors – such as communication and social skills – and reduce behaviors that may interfere with learning or may be harmful.

What the plan pays

The plan only pays benefits for covered charges for services and treatment that are **medically necessary and appropriate**, as determined by Beacon Health Options, the claims administrator. **Prior authorization** or **pre-certification** with Beacon Health Options is required prior to services being delivered. You're also required to obtain authorization on a recurring basis for continuing services, as required by Beacon Health Options. Based on an initial review and concurrent review of the case, a case-specific quantity of ABA therapy services will be allocated.

Covered ABA services are paid according to the **Outpatient Office Visit** schedule of benefits. You will be responsible for any cost sharing that applies to you, including the deductible, copayments or coinsurance. You can visit any ABA licensed or certified provider, network or out-of-network. But if you use of an out-of-network provider, covered services will be paid under the out-of-network portion of the MHSA Plan, which means you'll pay a larger share of the costs for service. Beacon Health Options can help you locate a network provider in your area. Review the **Mental Health and Substance Abuse Plan** summary plan description posted online at **hr2.chevron.com** for more information about how **Outpatient Office Visit** benefits are paid.

Covered ABA services

Covered ABA services may include:

- Psychiatric evaluation to confirm the ASD diagnosis.
- Psychological testing, as necessary to confirm the ASD diagnosis.
- Individual, family, and group therapy.
- Medication management.
- Applied Behavior Analysis (ABA) treatment.
- Intensive Case Management for complex cases (individuals with extraordinary care needs).

The MHSA Plan doesn't cover prescription drugs for ABA treatment. If the covered individual is prescribed a drug as part of treatment, you should check with your medical plan to find out if it can help pay for the drugs you need; otherwise, you'll be responsible for paying the full cost of prescribed outpatient medication.

Covered diagnoses

Covered diagnoses include autism, which is a general term used to describe a group of complex developmental brain disorders known as Pervasive Developmental Disorders (PDD) within the American Psychiatric Association Diagnostic and Statistical Manual 5 (DSM 5). Autism Spectrum Disorder (ASD) is a type of PDD. Your benefit covers Applied Behavior Analysis (ABA) treatment for ASD.

The other covered pervasive developmental disorders are:

- Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS)
- Asperger Syndrome
- Rett Syndrome
- Childhood Disintegrative Disorder

Only these diagnoses, along with a diagnosis of being at risk of autism or PDD, will be covered.

How to obtain prior authorization or pre-certification

Prior authorization or pre-certification will be required for benefits to be paid. You can obtain prior authorization or pre-certification with Beacon Health Options by calling them at **1-800-847-2438** after **December 1, 2017**. Once authorization is complete, a Beacon Health Options representative will advise you that ABA therapy will be covered according to the MHSA Plan's benefits when provided or supervised by a ABA licensed or certified provider of services effective January 1, 2018.

If a covered participant is currently receiving services, register with Beacon Health Options between December 1, 2017 and March 31, 2018 by calling 1-800-847-2438. After you register, ABA claims submitted to Beacon Health Options for dates of service from January 1, 2018 through March 31, 2018 will be paid at network benefit levels – even if your provider is out-of-network. This assumes that covered services are medically necessary and that services are provided by an ABA licensed or certified provider. ABA treatment rendered after March 31, 2018 must be performed by a Beacon Health Options network provider to be eligible for the network level of coverage under the MHSA Plan. Use of an out-of-network provider after the transition period will result in payment under the out-of-network level of coverage under the MHSA Plan. All ABA services require authorization, need to meet medical necessity requirements and must be provided by an approved, ABA licensed or certified provider.

For services rendered after March 31, 2018, if your provider is out-of-network, but is appropriately ABA licensed or certified and willing to join the Beacon Health Options ABA network, they can complete the necessary screening requirements and, if they are accepted into the Beacon Health Options network of providers, you may use their services and receive the network level of coverage. Ultimately, application for acceptance into the Beacon Health Options network is the provider's decision.

Mental Health and Substance Abuse Plan (MHSA) is a grandfathered health plan under the Patient Protection and Affordable Care Act. Chevron Corporation believes the Chevron Corporation Mental Health and Substance Abuse Plan (the MHSA Plan) is a grandfathered health plan under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 1-888-825-5247. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

mental health and substance abuse plan

effective january 1, 2018

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virtual visits

This change applies to the MHSA Plan

Virtual visits for certain covered conditions, as deemed medically appropriate by Beacon Health Options, will be covered under the MHSA Plan. Virtual visits will be accessed through a network of providers that have been approved to provide this remote treatment option. Virtual visits use interactive audio-visual communication technology. Benefits under this provision do not include email, fax or standard, audio-only telephone calls. In addition, telehealth/telemedicine visits that occur within behavioral health facilities will not be covered. Virtual visits will be available only in states where such access to mental health and substance abuse care is allowed. In addition, not all mental health and substance abuse conditions can be appropriately treated through virtual visits. More information about virtual visits, including how it works, will be provided when it becomes available.

dental PPO plan
effective january 1, 2020

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2D oral/facial photographic images

Applies to the Chevron Dental PPO Plan

Effective January 1, 2020 the Dental PPO Plan includes coverage for **2D oral/facial photographic images** covered at 50 percent under Orthodontic Care and subject to the orthodontic lifetime maximum. Contact Delta Dental of California at 1-800-228-0513 if you have questions.

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dental PPO plan
expatriates in the U.S.
when there is no network provider near you
effective january 1, 2019

human energy. yours.™

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dental PPO plan

With the Dental PPO Plan, you can see any U.S. dentist you choose, but using a network provider saves you money by reducing your out-of-pocket costs. Your share of the cost for covered services – or coinsurance – is often lower. In addition, you don't have to file claim forms, or worry about balance billing for covered services when you see a network provider.

However, there may be times when there is not a network provider where you live. **To assist with these limited situations, effective January 1, 2019, the Dental PPO Plan will pay 90 percent of Delta Dental's allowance for covered basic dental care services provided by out-of-network providers if there is no Delta Dental PPO℠ network or Delta Dental Premier® network provider within 45 miles of your home zip code.** You will also pay the difference between your dentist's fees and Delta Dental's allowance. Go to the summary plan description posted online at **hr2.chevron.com** for a listing of what's considered basic dental care services.

check both the dental PPO networks for a provider

To be eligible for the 90 percent coinsurance amount when using an out-of-network provider, you'll need to make sure there is no network provider within 45 miles of your home zip code in either the **Delta Dental PPO network** or the **Delta Dental Premier network**. Use the **Find a Provider** link available on **hr2.chevron.com/openenrollment** to start your search for a Delta Dental network provider.

As a reminder, Delta Dental offers two different types of networks: the **Delta Dental PPO℠ network** and the **Delta Dental Premier® network**. Both options are considered network providers, so they cover the same services, have the same annual maximums, the same coinsurance or copayment levels, and covered services from these providers aren't subject to the deductible. The difference between the two comes down to the reduced fees the dentists have agreed to provide Dental PPO plan participants.

chevron dental plan

The **Chevron Dental Plan** is a preferred provider organization (PPO) dental plan. Delta Dental of California (Delta Dental) is the claims administrator. The Dental Plan changes described below will take effect January 1, 2018.

dental plan changes

The following x-ray limitations have been changed to align with FDA and ADA guidelines on radiation exposure:

- **Bitewing x-rays**
  - To age 18, **two** per calendar year.
  - Over age 18, **one** in a calendar year.
- **Full mouth x-rays**
  - **One** in 60 months, combine with panoramic x-rays.
- **Panoramic x-rays**
  - One in 60 months, combine with full mouth x-rays.

Other plan changes include:

- **Debridement**, *one* per lifetime.
- **Root canal re-treatment**, *one* in 24 months.
- **Pulpal therapy**, covered on primary teeth, with no age limitations. Pulpal therapy is not covered on permanent teeth.
- The previous **coverage exclusion for dental implants** that replace natural teeth lost while *not covered* under the Chevron Dental PPO Plan has been *removed*.
- **Oral pathology laboratory (labs and tests)**, covered as a diagnostic service.

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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.)

Healthy You Program (WebMD)
You can access the HR2 website on the Internet, from home or at work. Learn more about the program, take the health questionnaire, use the WebMD website tools and resources or schedule a health coach session.

Why contact this administrator

- To participate in the Healthy You program tools and resources, including the voluntary health questionnaire (HQ) and health coaching.
- To inquire about your points status for purposes of determining eligibility requirements toward Health Rewards.

Phone information

- 1-888-321-1544 (from inside the U.S.)
- 925-842-8346 (from outside U.S.)

Website information

- To activate your account, take the Healthy You program voluntary HQ, record and review your health rewards points, learn about or use the Healthy You program tools and resources.
- **hr2.chevron.com/webmd**

Other contact information

- heart@chevron.com

WebMD Wellness At Your Side mobile app available on the Apple App Store or Google Play.

Beacon Health Options
Mental Health and Substance Use Disorder Plan

- **1-800-847-2438** (714-763-2420 outside the U.S.)
- MDLive For telebehavioral health services **1-888-430-4827**
- **www.achievesolutions.net/chevron**

Delta Dental of California
Dental PPO Plan (Expatriates in the U.S.)

- (Inside U.S.) 1-800-228-0513
- (Outside U.S.) 415-972-8300
- **www.deltadentalins.com/chevron**

who's eligible to participate

This section provides information about benefit plan eligibility rules for Chevron health plans for expatriates working in the U.S. and their eligible dependents.

Note: If you are not an employee working in the U.S. on expatriate assignment, then you are not eligible for the Global Choice Plan (Expatriates in the U.S.) as described in this SPD. If you are a global offshore payroll employee working in the U.S. your benefits are described on the Chevron intranet at hr.chevron.com/benefits/.

eligible employees

Except as described below, you're generally eligible for certain Chevron health care plans as an Expatriate in the U.S. 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 a non-U.S. Chevron payroll.
- You are a citizen of a country other than the U.S.
- You are employed by or on assignment to Chevron Corporation or a participating company.
- You are assigned to and working in the U.S. on an expatriate assignment that is expected to last at least three months.
- You are not a Global Offshore payroll employee.
- You would meet the following requirements, but for the fact that you are on a non-U.S. payroll of Chevron Corporation or a participating company:
  - At least age 18 and of legal age.
  - You are a common law employee of Chevron or a participating company.
  - You're assigned to a regular work schedule (unless you're on a family leave, disability leave, short union business leave, furlough leave, military service leave or leave with pay) of at least 40 hours a week, or at least 20 hours a week, if such schedule is an approved part-time work schedule under the Corporation's part-time employment guidelines.
  - If you're a casual employee, you've worked (or are expected to work) a regular work schedule for more than four consecutive months.
  - If you're designated by Chevron as a seasonal employee, you're not on a leave of absence.
  - You're in a class of employees designated by Chevron as eligible for participation in the plans.

Note: This plan only applies to Expatriates in the U.S. (as described above) that are not on the U.S. payroll. This plan is your only option for Chevron-sponsored medical coverage as an Expatriate in the U.S. If you are an expatriate on the U.S.-payroll, refer to hr2.chevron.com to find information about the Global Choice (U.S.-Payroll Expatriates) coverage that applies to you.

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

- You're not on a Chevron 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 plans. Subject to the plans' administrative review procedures, Chevron Corporation's determination is conclusive and binding.

If you have questions about your eligibility for a particular Chevron plan, you should contact your Expatriate Counselor or the Chevron Human Resources Service Center:

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

eligible dependents

You can participate in the benefit plans offered to employees working as an expatriate in the U.S. if you are an eligible Expatriate in the U.S. If you enroll for coverage under the Global Choice Plan (Expatriates in the U.S.) or the Chevron Dental Plan (Expatriates in the U.S.), 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 and eligible children, as all are defined in this section. If your home country benefits include a domestic partner as an eligible dependent for coverage under medical benefits, you can also add your domestic partner to coverage in the U.S.

Eligible Spouse

If you're legally married and your marriage is recognized as valid under the laws of your home country, you can enroll your spouse for coverage — under the same medical and dental 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. Your common-law spouse isn't eligible for coverage unless your marriage is recognized as valid under the laws of your home country. Only one spouse can be covered under this plan.

Eligible Domestic Partner

Generally, you can enroll your domestic partner in health care coverage while you are on an expatriate assignment in the U.S., but only if your domestic partner is eligible for coverage under the Company-sponsored medical plan (or government-sponsored health plan where provided in your home country) in which you would participate if you were working in your home country. You cannot 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 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 (if your domestic partner is approved in your home country) 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 - if your domestic partner is approved in your home country) 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 also 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 Chevron's medical plan administrator you must provide documentation every two years. If the disability is not chronic, Chevron's medical plan 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 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 information about benefit plan participation rules in Chevron health plans for expatriates working in the U.S. and their eligible dependents.

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 (Expatriates in the U.S.) (includes prescription drug and basic vision coverage)	If you are an eligible expatriate in the U.S., your coverage is automatic. Coverage is not automatic for your eligible dependents. You can enroll your eligible dependents in the Global Choice Plan when your expatriate assignment begins. For dependent coverage to begin on the date your expatriate assignment begins, you must enroll them within 31 days of that date. 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.	To enroll, contact your Assignee Counselor. If you don't enroll your eligible dependents at the same time you enroll yourself, you can enroll them during any open enrollment period or within 31 days of the date they first become eligible (for example, within 31 days of a qualifying life event).
Mental Health and Substance Abuse Plan	If you are an eligible expatriate in the U.S. your coverage is automatic. Coverage for your dependents is also automatic if your dependents are enrolled in the Global Choice Plan. If your dependents aren't enrolled in the Global Choice Plan, they're not eligible for Mental Health and Substance Use Disorder Plan coverage.	Coverage is automatic if you and your dependents meet eligibility requirements. Dependents must be enrolled in the Global Choice Plan to be covered.
Dental PPO	If you are an eligible expatriate in the U.S., your coverage is automatic. Coverage is not automatic for your eligible dependents. You can enroll your eligible dependents in the Dental PPO Plan when your expatriate assignment begins. For dependent coverage to begin on the date your expatriate assignment begins, you must enroll them within 31 days of that date. 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.	To enroll, contact your Assignee Counselor. If you don't enroll your eligible dependents at the same time you enroll yourself, you can enroll them during any open enrollment period or within 31 days of the date they first become eligible (for example, within 31 days of a qualifying life event).

making changes

You can enroll in coverage or add coverage for eligible dependents when you:

- First become eligible.
- Have a qualifying life event.
- During the open enrollment period each year (which is typically held during a two-week period each fall). Changes take effect the following January 1.

If you want to change or cancel coverage, contact your Assignee Counselor.

Midyear Changes

Under certain circumstances, you can enroll for or change coverage during the year (for example, if you experience a qualifying life event that affects your, your eligible 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 eligible 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.
- If your home country benefit rules allow coverage for a domestic partner and the 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, if your home country benefit rules allow coverage for 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).
- 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 your Assignee Counselor 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 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.

Special Enrollment Due to Loss of Other Coverage

You and your eligible dependents can enroll for health 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 your 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 if 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 an eligible dependent through marriage birth, adoption or placement for adoption. If your home country benefits include a domestic partner as an eligible dependent for coverage under medical benefits, you can also add your domestic partner to coverage in the U.S. upon formation of a new domestic partnership. You and your dependents must request special enrollment in writing no later than 31 days from the date of the qualifying life event. 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 eligible 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 at the time of your marriage. You also can enroll your spouse or eligible 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, acquiring a new eligible 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 who becomes your dependent as a result of your marriage or acquiring a new eligible 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:**
  - **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 within your home country are 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 (Expatriates in the U.S.) (includes prescription drug and vision coverage)	
Type of Coverage	**Participation Begins:**
Employee Coverage	• On the effective date of your expatriate assignment. • On the day 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 you meet the requirements of your country for adding an eligible domestic partner. • The following January 1, if you enroll during the open enrollment period.
Dependent Coverage	• 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 or 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.

Mental Health and Substance Use Disorder Plan
Participation begins: • On the effective date of your expatriate assignment. • If your dependents are enrolled in the Global Choice Plan, they're also automatically enrolled in this plan. Dependents begin participation in the Mental Health and Substance Use Disorder Plan when they begin participation in the Global Choice Plan.

Dental PPO	
Type of Coverage	**Participation Begins:**
Employee Coverage	• On the effective date of your expatriate assignment. • On the day 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 you meet the requirements of your country for adding an eligible domestic partner. • The following January 1, if you enroll during the open enrollment period.
Dependent Coverage	• 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 or 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.

when participation ends

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

- You're no longer an eligible employee (for example, if your expatriate assignment ends).
- 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 (Expatriates in the U.S.) (includes prescription drug and basic vision coverage)	• You or your dependent is no longer eligible. Coverage ends on the last day of the month. • On the last day of the month in which your resident expatriate assignment ends. If you or a dependent is hospitalized at the time coverage under the Global Choice Plan ends, benefits for charges incurred in the hospital can be paid until you or your dependent leaves the hospital.
Mental Health and Substance Use Disorder Plan	• You are no longer eligible. • Your dependent's coverage under the medical plan ends.
Dental PPO	• You or your dependent is no longer eligible. Coverage ends on the last day of the month. • On the last day of the month in which your resident expatriate assignment ends.

What Happens if You Die

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

how much you pay for coverage

Chevron Corporation, in its sole discretion, determines the amount that plan members contribute for health care plan coverage. Currently, Chevron pays the entire monthly premium for your health care coverage.

global choice plan (expatriates in the U.S.)

This section provides a description of the Global Choice Plan for you and your eligible dependents. This section includes a description of the following components of this plan:

- Medical Coverage
- Prescription Drug Coverage
- Basic Vision Coverage

medical coverage
global choice plan

If you are an expatriate working in the U.S. and an eligible employee as described under the Eligibility section of this SPD, then you are eligible to participate in the Chevron Corporation Global Choice Plan (Expatriates in the U.S.) 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 expatriate employees working in the U.S. 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 only discusses medical coverage. For more information about the prescription drugs, vision, dental, mental health and substance use disorder coverage, 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.
- 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

Member Services

- 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

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 an out-of-pocket maximum under the Global Choice Plan that applies when you use out-of-network providers inside the U.S. You can read more about this in the Certificate of Coverage.
- If you receive medical services inside the U.S., there are different levels of benefits for network providers and out-of-network providers. When you receive care for covered services from a network provider in the U.S. the plan pays 100 percent of charges. You always have the option of using an out-of-network provider, but plan will generally cover only 70 percent of charges for covered services and you are responsible for paying the remaining charges. You can locate a list of network providers in the U.S. on the Cigna website at **www.cignaenvoy.com**.
- 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
- There are no network providers outside the U.S., however when obtaining services outside the U.S. the plan reimburses you 100 percent of covered charges.
- 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. You do not need to file a claim when using network providers or facilities in the U.S. You should file a claim for reimbursement when you:

- Obtain medical services from an out-of-network provider inside the U.S.
- Obtain medical services from a provider outside the U.S.
- Obtain prescription drugs outside the U.S. (For reimbursement of prescription drugs obtained inside the U.S., refer to the Prescription Drugs section in this SPD.)

Note that if you are using out-of-network providers 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 a claim is overpaid 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. When you receive services from an out-of-network provider, you are responsible for filing a claim to request 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 for care outside the U.S., you usually have to pay at the time you receive services 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 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 (or its delegate) 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 non-urgent 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.

Claim Review Process: 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.			
	Types of Claims		
Time Limits	**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 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	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 to give you a reasonable opportunity to respond prior to the decision being issued.

Notice of Decision on 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.

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 (Expatriates in the U.S.).

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 PPO 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 PPO 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. 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). 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 PPO 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 PPO 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 PPO Plan in case of accidental injury to teeth.

prescription drug coverage
global choice plan

This section provides a description of the prescription drug coverage under the Global Choice Plan (Expatriates in the U.S.) for you and your eligible dependents. When you enroll in the Global Choice Plan, prescription drug benefits for prescriptions obtained inside and outside 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 **inside** the U.S. (Express Scripts – Chevron Prescription Drug Program)

- A benefit for prescription drugs obtained **outside** the U.S. (Cigna – Global Choice Plan)

This section only discusses prescription drug coverage. For more information about medical, vision, dental, mental health and substance use disorder coverage, see the corresponding sections in this SPD.

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

overview of prescription drug benefit (express scripts)

Covered prescription drugs 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 also 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 the home delivery pharmacy service components of the program. To receive 100 percent coverage, 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)** The plan pays:	**Retail Pharmacy - U.S. (out-of-network)*** The plan pays:	**Home Delivery Service** The plan pays:
Generic Drugs	100%	70%	100%
Preferred Brand-Name Drugs	100%	70%	100%
Non-Preferred Brand-Name Drugs	100%	70%	100%
Specialty Maintenance Drugs	First fill: 100% Refills at retail: 0%	First fill: 70% Refills at retail: 0%	100%
Supply Limit	Up to a 30-day supply	Up to a 30-day supply	Up to a 90-day supply
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

***Network Pharmacies vs. Out-of-Network Pharmacies**
When you use a retail pharmacy 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 70% of the prescription cost.

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

Under this Prescription Drug Program 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:

- 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 this part of the Prescription Drug Program if the above criteria are met, including the following drugs and supplies:

- Smoking deterrents.
- Prescribed FDA approved female contraceptive methods including prescribed contraceptives which can be purchased over-the-counter.
- 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.
- Doctor prescribed medications for preventive care as required by the Patient Protection and Affordable Care Act. 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 of 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.

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 quantity limits can be obtained at any time from Express Scripts or on the ESI website.

Preferred Drug Step Therapy

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 doctor to review the therapy and determine whether the drug can be covered. You and your doctor will be notified when this process is completed. If the medication isn't approved, you'll be responsible for paying the full cost of the drug.

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

Medical Channel Management

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

- Cancer – oral medications
- Growth Stimulating Agents
- Hemophilia – nasal medications
- HIV

- Immune Deficiency
- Infertility
- Metabolic Disorders
- Multiple Sclerosis
- Osteoporosis
- Parkinson's Disease
- Pulmonary – Cystic Fibrosis
- Rheumatoid Arthritis and other Autoimmune Conditions
- Short Bowel Disease

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

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.

how to get your medication

When You Go to a Network Pharmacy (in the U.S.)

You can fill prescriptions for up to a 30-day supply of covered medication at any Express Scripts network pharmacy. Show your prescription ID card to the pharmacist or provide your Express Scripts ID number when you hand in your prescription. When you have your ID card or your Express Scripts ID number, you will pay nothing ($0). **If you don't have your prescription ID card or your Express Scripts ID number, and the pharmacist can't confirm your eligibility, you will have to pay the full cost and file a claim for reimbursement. These claims are reimbursed as an out-of-network benefit and you are reimbursed 70 percent of the billed charge.**

You'll receive a generic version of the drug, unless a generic version is not available, or if your doctor specifies that you receive a brand-name by writing *Dispense as Written* on your prescription.

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

When You Go to an Out-of-Network Pharmacy (in the U.S.)

If you go to a pharmacy that's out-of-network to fill prescriptions for up to a 30-day supply of covered medication, you pay the full price of the prescription, then file a claim form with Express Scripts. You are reimbursed 70 percent of the billed charge for your prescription.

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 90-day supply of covered prescription drugs. You should consider using this part of the program when you need maintenance medication, when possible. Allow two to three weeks for new prescriptions.

Note: Because of the time required for home delivery shipments, this part of the Prescription Drug Program isn't suitable for one-time prescriptions, for emergencies, or for temporary conditions.

How to Order Medication by Mail

- Ask your doctor for a prescription for up to a 90-day supply of medication, with up to three refills. If you need medication immediately, ask your doctor to write another prescription for a 14-day supply and have it filled at a network pharmacy.

- If your doctor wants to try a new maintenance drug for a brief time, ask for two prescriptions – one for a small supply to monitor the drug's effectiveness and the second for a 90-day supply with refills. Take the first prescription to a network pharmacy to be filled. After you and your doctor determine that the new drug is effective, send the other prescription to the home delivery pharmacy.

- 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.

Note: Express Scripts can only fill prescriptions written by U.S.-licensed doctors and can only mail to addresses within the United States.

Ordering Prescription Refills by Mail

A reorder form and envelope are included with each prescription you order using the home delivery pharmacy. To order a refill of your prescription, follow the instructions on the reorder form, visit **www.Express-Scripts.com** or call Express Scripts Member Services at 1-800-987-8368. You should order refills three weeks before your current supply runs out. Prescriptions are valid for up to 12 months. After that, you must ask your doctor for a new prescription.

Special Vacation Supply of Prescription Medication

If you're planning to travel and you need medication while you're away:

- You can call Express Scripts Member Services at 1-800-987-8368, or log on to the website at **www.Express-Scripts.com** to find out how to arrange for an early refill of your medication. (Vacation supply requests are limited to two per 180 days.)

- You can call Express Scripts Member Services to get a list of network pharmacies in the areas you'll visit.

- You can order the medication you need ahead of time, using the program's home delivery pharmacy.

- You can go to an out-of-network pharmacy while you're on vacation and pay the entire cost and file a claim for reimbursement. If the pharmacy is inside the U.S., file your claim with Express Scripts under the Chevron Prescription Drug Program. The claim is reimbursed as out-of-network, so the benefits will be lower than if you used one of the other options listed above. If the pharmacy is outside of the U.S., file your claim with Cigna under the Global Choice Plan.

how to file a prescription drug claim with express scripts

This section briefly describes how to file a claim for prescription drugs (obtained inside the U.S.) that you believe are eligible for reimbursement under the Prescription Drug Program. For prescriptions filled outside the U.S., see the 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. (The plan administrator for the Prescription Drug Program determines whether you or a dependent is eligible to participate in the Prescription Drug Program.)

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, if any, 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.
- 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 Scripts' 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 Express Scripts member ID number. 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 in the Claims Review and Appeals section. You also should be aware that Express Scripts has the right to request repayment if it overpays a claim for any reason.

Note: For information on how to file a medical benefit claim or a basic vision claim, please see the Global Choice Plan – Medical Coverage and the Global Choice Plan – Basic Vision Coverage sections.

prescription drug claim review 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 (defined under Initial Review and Decision in the Prescription Drug Claims section), 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 and/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.

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 all of 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 502(a) under 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 all of 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 under 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 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.

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.

If your second appeal is denied, you have the right to take legal action.

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
1-800-743-2851
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:

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

1-800-743-2851
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.

claims for coordination of benefits under the 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 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 PPO Plan in case of accidental injury to teeth.

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 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.
- 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 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. heading in this 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. 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

- 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
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300 Bellevue Parkway
Wilmington, DE 19809

How to Contact Cigna

Customer Service

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

prescription drug claims review and appeals with cigna

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

Initial Review and Decision

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

Types of Claims

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

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

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

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

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

Time Limits for Processing Claims

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

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

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

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

Time Limits for Processing Claims *This chart describes the time limits for processing different types of claims.*			
	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 (or its delegate) 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 non-urgent 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 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 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	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.

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

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 to give you a reasonable opportunity to respond prior to the decision being issued.

Notice of Decision on 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.

The claims administrator 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 and appeals.

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.

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.

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

basic vision coverage
global choice plan

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

- Chevron Vision Program - VSP Vision Care (VSP)

This section only discusses basic vision coverage under the Global Choice Plan. For more information about medical, prescription drugs, dental, mental health and substance use disorder coverage, see the corresponding sections in this SPD.

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 (Expatriates in the U.S.)
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.

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

how to use your basic vision benefit

To use your vision benefits, 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.

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 at 916-851-5000 (press “0” for operator assistance) if you’re outside the U.S., 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.
- 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.

dental PPO plan

This section provides a description of the Dental PPO Plan for you and your eligible dependents.

If you are an expatriate working in the U.S. and an eligible employee as described under the Eligibility section of this SPD, then you are eligible to participate in the Chevron Dental Plan (also referred to as the Dental PPO).Your only option for Chevron-sponsored dental coverage as an expatriate working in the U.S. is the Dental PPO.

overview

The Chevron Dental Plan (also referred to as the Dental PPO) is designed to help you pay for diagnostic, preventive, basic restorative and major dental care, up to certain benefit maximums. Delta Dental of California (Delta Dental) is the claims administrator of the Dental PPO Plan.

- Delta Dental offers two different types of networks. Both options are considered **network** providers, so they cover the same services, have the same annual maximums, the same coinsurance or copayment levels, and covered services from these providers aren't subject to the deductible. You also don't have to worry about balance billing when you see a provider from either network option. The difference between the two comes down to the contracted fees the dentists have agreed to provide Dental PPO plan participants.
- **If you go to a dentist in the U.S. who is out-of-network, you qualify for out-of-network coverage. When you see a U.S. provider who is out-of-network, you're required to pay the difference between your dentist's charge and Delta Dental's allowance for services received in the U.S.**
- The plan will reimburse 100 percent of covered charges when you use a network provider or when you obtain services outside the U.S. When you use an out-of-network provider in the U.S., the plan generally reimburses you 70 percent for covered charges and the remaining cost is your responsibility.
- Every calendar year, you and each enrolled family member can qualify for up to $2,000 in U.S. network and non-U.S. benefits or up to $1,500 in U.S. out-of-network benefits.
- In addition, for orthodontic care for plan members, the plan can pay up to a lifetime maximum of $1,500 for U.S. network and non-U.S. benefits or $1,000 for U.S. out-of-network benefits.
- The plan can pay up to a lifetime maximum of $750 for TMJ care for plan members.
- You can enroll in this plan when you first become an eligible employee, during open enrollment or when there's a qualifying life event.
- There are no network providers available outside the U.S. When you see a dentist outside the U.S., you must pay the provider directly for services. You must file a claim and the plan will reimburse you for eligible expenses based on billed charges.

Note: The contracted fee, which participating PPO and Premier dentists agree to accept, is the basis for plan reimbursement while receiving network benefits for services received inside the U.S.

Important: Any U.S. network and non U.S. benefits you use count toward your annual maximum or lifetime maximums for U.S. out-of-network benefits. Similarly, any U.S. out-of-network benefits you use count toward your annual or lifetime maximum for U.S. network and non-U.S. benefits. For example, if a plan member has received $1,000 in benefits under U.S. network coverage and $500 under U.S. out-of-network coverage, no further U.S. out-of-network benefits are payable for that individual, because the $1,500 annual benefit maximum has been reached. However, that individual could qualify for another $500 in benefits under U.S. network coverage — bringing total paid benefits up to the $2,000 annual network coverage benefit maximum. This same principle applies to the Lifetime Maximum for Orthodontics and TMJ-related services.

how the plan works

If receiving services in the U.S, you and your enrolled dependents can decide whether to go to a network dentist — or an out-of-network dentist — when you need dental care. This decision determines whether the care you receive qualifies for network coverage or out-of-network coverage. Your out-of-pocket expenses generally will be lower when you receive services from a network provider than for the same services received from an out-of-network provider.

If you go to a Network Provider (In the U.S.)

The Delta Dental PPO℠ network and the Delta Dental Premier® network. are only available in the U.S. The plan pays 100 percent of covered charges when you use a provider in either network. -To find Delta Dental PPO℠ network or Delta Dental Premier® network providers near you, visit **www.deltdentalins.com/chevron** **or** call Delta Dental at 1-800-228-0513 (inside the U.S.) or. You don't have to file claim forms.

If you go to an Out-of-network Provider (In the U.S.)

When you receive care from a dentist who doesn't participate in the Delta Dental PPO℠ network or Delta Dental Premier® network, the plan will generally pay 70 percent of Delta Dental's allowance for covered charges for out-of-network care. You will pay the remainder on your own. Neither the plan nor Chevron will reimburse you for the charges you must pay on your own.

If you go to a Non-U.S. Provider

The Delta Dental PPO℠ network and the Delta Dental Premier® network are only available in the U.S. Generally, the plan pays 100 percent of billed charges when you obtain services outside the U.S. You will be required to pay for the services when you receive them and submit a claim form to Delta Dental to receive reimbursement for covered expenses.

deductibles

There is no deductible for this plan.

benefit maximums

Every calendar year, you and each enrolled family member can qualify for up to $2,000 in U.S. network benefits and non-U.S benefits, or up to $1,500 in U.S. out-of-network benefits. In addition, for orthodontic care for plan members, the plan can pay up to a lifetime maximum of $1,500 in U.S. network benefits and non-U.S. benefits, or $1,000 in U.S. out-of-network benefits, with no deductible requirement. These benefits are not counted when determining if the plan's annual maximums have been reached.

Nonsurgical treatment of temporomandibular joint dysfunction (TMJ) has a lifetime benefit maximum of $750 for each plan member. These benefits are not counted when determining if the plan's annual maximums have been reached.

Important: Any U.S. network and non-U.S. benefits you use count toward your annual maximum or lifetime maximums for U.S. out-of-network benefits. Similarly, any U.S. out-of-network benefits you use count toward your annual or lifetime maximums for U.S. network and non U.S. benefits. For example, if a plan member has received $1,000 in benefits under U.S. network coverage and $500 under U.S. out-of-network coverage, no further U.S. out-of-network benefits are payable for that individual, because the $1,500 annual benefit maximum has been reached. However, that individual could qualify for another $500 in benefits under U.S. network coverage — bringing total paid benefits up to the $2,000 annual U.S. network coverage benefit maximum. This same principle applies to the Lifetime Maximum for Orthodontics and TMJ related services.

Note: If you or your enrolled dependents reach a benefit maximum when using network providers, then the participating provider can charge his or her normal fee for future services. In this case, the provider is not bound by the contracted fee schedule.

what the plan pays

Network coverage and out-of-network coverage help pay for the following kinds of care:

- Diagnostic and preventive care.
- Basic dental care.
- Major dental care, including implants.
- TMJ Services (non-surgical).
- Orthodontic care.

Diagnostic and Preventive Care

To encourage you and your dependents to take good care of your teeth, the plan can pay 100 percent of covered charges for routine diagnostic and preventive care, such as checkups and cleanings.

- **Network coverage:** Pays 100 percent of the contracted fees for covered charges.
- **Out-of-network coverage (services in the U.S.):** Pays 70 percent of Delta Dental's allowance for covered charges. (You pay the difference between your dentist's fees and Delta Dental's allowance.)
- **Out-of-network coverage (services outside the U.S.):** Pays 100 percent of billed charges for covered charges.

These benefits are subject to the plan's annual benefit maximums.

The following services and supplies are covered for each enrolled member of your family:

- Two oral examinations per calendar year.
- Cleaning and scaling of teeth (called prophylaxis) performed by a dentist or dental hygienist twice per calendar year (an additional dental cleaning will be covered for pregnant women).
- Periodontal cleanings twice per calendar year following active periodontal therapy, in addition to cleaning and scaling of teeth (prophylaxis).
- Bitewing X-rays twice per calendar year.
- Full-mouth or panoramic X-rays once every 36 months.
- One sealant treatment of the permanent posterior teeth every 36 months for each covered child under age 14.
- Two fluoride treatments per calendar year for each plan member under age 19.

- Space maintainers, and required adjustments to them, for plan members under age 19 that are due to premature loss or extraction of teeth, and necessary to prevent adjacent or opposing teeth from moving.

- Emergency treatment to relieve dental pain, including charges for X-rays (other kinds of care provided on the same day will be paid according to the plan's basic, major and orthodontic care coverages).

Basic Dental Care

- **Network coverage:** Pays 100 percent of the contracted fees for covered charges.
- **Out-of-network coverage (services in U.S.):** Pays 70 percent of Delta Dental's allowance for covered charges. (You pay the difference between your dentist's fees and Delta Dental's allowance.)
- **Out-of-network coverage (services outside the U.S.):** Pays 100 percent of billed charges for covered charges.

Covered basic dental care includes the following:

- **Fillings:** Amalgam, silicate, acrylic, synthetic, porcelain and composite fillings (anterior teeth only) to repair teeth that are broken or decayed. Coverage for composite fillings in posterior teeth is limited to the covered amount for amalgam fillings. Gold fillings are covered under major dental care. Replacement of restorative services only when they are not, and cannot be made serviceable, including basic restorations (not within 12 months of previous placement).

- **Oral surgery:** Tooth extractions, treatment of a fractured or dislocated jaw, cutting procedures (including removal of stitches and postoperative examinations), and the medically necessary anesthesia when performed by a dentist or an oral surgeon in his or her office, including when prescribed as part of an orthodontic treatment plan.

  Note: When oral surgery is performed in a facility other than the oral surgeon's office, the oral surgeon's fees will be covered, but the facility and anesthesia charges will be excluded. Coordinate with your medical plan for facility and anesthesia coverage.

- **Periodontics:** Treatment of the gums (including scaling and root planning) and supporting tissue.
  - Scaling and root planning – not within 24 months of previous treatment.
  - Periodontal surgery, not more than once within 36 months of previous treatment.
- **Endodontics:** Root canal therapy and other treatments related to dental pulp as follows:
  - Root canal re-treatment – one per tooth per lifetime.
  - Pulpal therapy – one per eligible tooth per lifetime. Eligible teeth limited to primary anterior teeth under age six and primary posterior molars under age twelve.
- **Antibiotic injections:** Injectable antibiotics only.
- **Crowns and inlays:** Adjustments and recementing of crowns and inlays more than 24 months after initial installation. (Initial installation of crowns and inlays is covered under major dental care.) Recementation allowed once per twelve months. Recementation during the first six months following insertion of the crown or bridge by the same dentist is included in the cost of the initial crown or bridge when services are received by a network provider. Crown repairs are also covered under this category.

- **Bridgework and dentures:** Repairs, adjustments and recementing of bridgework or dentures, relining or rebasing of dentures and charges for adding teeth to existing dentures, if needed to replace teeth while covered under the plan. Adjustments, relining or rebasing done within six months after initial installation aren't covered under the basic dental care. (Initial installation of bridgework and dentures and the first six months of their maintenance are covered under major dental care.)

- **Second opinions:** Covered if provided by an independent consulting dentist.

- **Lab tests and reports:** The plan covers lab tests and reports necessary for diagnosis, such as microscopic exams and tests of cysts from oral surgery.

Major Dental Care

- **Network coverage:** Pays 100 percent of the contracted fees for covered charges.

- **Out-of-network coverage (services in the U.S.):** Pays 70 percent of Delta Dental's allowance for covered charges. (You pay the difference between your dentist's fees and Delta Dental's allowance.)

- **Out-of-network coverage (services outside the U.S.):** Pays 100 percent of billed charges for covered charges.

Covered major dental care includes the following:

- **Prosthodontics:** Initial installation of bridgework and full or partial dentures is covered under this part of the plan. Benefits payable for both a temporary and permanent appliance are limited to covered charges for the permanent appliance. (Charges for extractions and other preparatory work, as well as repair, adjustment, recementing, relining, rebasing and adding teeth to existing dentures more than six months after their initial installation are covered under basic dental care.)

- **Cast Restorations:** Initial installation of crowns and inlays is covered under this part of the plan. Gold inlays, gold onlays and gold fillings and gold and porcelain crowns are covered only when the tooth can't be restored with fillings using the materials covered under basic dental care. If the other materials can be used, benefits for the gold restoration will be limited to the amount that would be paid for the alternate materials.

- **Dental implants:** Dental implants are covered only if they're used to replace natural teeth lost while the patient is covered under the plan. Before you receive services your dentist must provide a copy of an Explanation of Benefits to Delta Dental to prove that your missing tooth was extracted and covered under the plan.

- **Nonsurgical treatment of temporomandibular joint dysfunction (TMJ), including occlusal guards:** Nonsurgical treatment of TMJ has a lifetime benefit maximum of $750 per covered member of your household. These benefits aren't counted when determining if the plan's annual benefit maximums have been reached.

  Treatment for TMJ includes examinations and the installation and adjustment of removable appliances designed to correct the condition. Charges for surgery to correct TMJ aren't covered under this plan, but may be covered under your medical plan.

Orthodontic Care

Any U.S. network and non-U.S. orthodontia benefits you use count toward your maximum U.S. out-of-network orthodontia benefits. Similarly, any U.S. out-of-network orthodontia benefits you use count toward your maximum U.S. network and non-U.S. orthodontia benefits. For example, if a plan member has received $500 in benefits for orthodontic care under U.S. network coverage and $500 under U.S. out-of-network coverage, no further U.S. out-of-network orthodontia benefits are payable for that individual, because the $1,000 lifetime benefit maximum has been reached. However, that individual could qualify for another $500 in orthodontic care benefits under the plan's U.S. network coverage — bringing total paid benefits up to the $1,500 lifetime network coverage benefit maximum.

If installation of appliances occurs before coverage is in effect, orthodontic services will be covered on a prorated basis once coverage begins under the plan.

- **U.S. Network coverage:** Pays 100 percent of the contracted fees for braces and other teeth-straightening services and appliances, including second opinions. There is a lifetime benefit maximum of $1,500 per plan member.

- **Out-of-network coverage (services in the U.S.):** Pays 70 percent of Delta Dental's allowance for braces and other teeth-straightening services and appliances, including second opinions. There is a lifetime benefit maximum of $1,000 per plan member.

- **Out-of-network coverage (services outside the U.S.):** Pays 100 percent of billed charges for braces and other teeth-straightening services and appliances, including second opinions, there is a lifetime benefit maximum of $1,500 per plan member.

Benefits paid for orthodontic care don't count toward the plan's annual individual benefit maximums.

If you go to an out-of-network dentist in the U.S. for care, you should ask the dentist to prepare a request for predetermination of benefits and send it to Delta Dental's, the plan's claims administrator, before orthodontic treatments are started. That way, you and your orthodontist will find out in advance how much the plan's U.S. out-of-network coverage will pay for the treatment and what you'll be required to pay.

The plan's orthodontia benefits for U.S. network coverage are paid in equal installments. Payments begin when the first orthodontic appliance is inserted. The last payment is made approximately two years after payments begin or, if sooner, when the treatment is completed, or will cease when that individual's coverage in the plan ends.

Note: Charges for tooth extractions and space maintainers are covered under basic dental care.

SmileWay® Wellness Benefits

For people with certain health conditions, having gum disease (periodontal disease) is fairly common. Inflammatory agents from the mouth can affect other areas of the body which are already under stress from chronic illness. If you or a covered dependent have a covered health condition, you can get additional benefits through the SmileWay® Wellness Benefits that makes gum disease treatment more affordable. This program is available at no cost to you. The additional benefits are:

SmileWay® Wellness Benefits

- 100% coverage for one periodontal scaling and root planing procedure per quadrant (D4341 or D4342) per calendar or contract year
- Four of the following (any combination) per calendar or contract year:
  - Prophylaxis (teeth cleaning) (D1110 or D1120), covered at 100%
  - Periodontal maintenance procedure (D4910), covered at 100%

The medical conditions eligible for the Smile for Health Program are:

- Diabetes
- Heart (coronary artery) disease
- HIV/AIDS
- Rheumatoid arthritis
- Stroke (cerebrovascular) disease

if your care costs more than $300

If the dental care you need is expected to cost more than $300 and the care will be provided in the U.S., you can find out, before you receive care, how much you will pay and how much the plan will pay.

For dental care in the U.S. just ask your dentist to request a predetermination of benefits by submitting a pre-treatment estimate request online or by mail, using the Delta Dental claim form. Your dentist should describe the treatment he or she recommends and send it to Delta Dental, the plan's claims administrator. You can get a copy of the predetermination of benefits claim form from Delta Dental's customer service group at 1-800-228-0513

Delta Dental will send you a letter explaining how much the plan's coverage will pay for the proposed care. In some cases, the letter also will include suggestions for alternative treatments that are less expensive than those your dentist recommends.

It's important for you and your dentist to get this information before treatment begins because the benefits paid will be based on covered charges for the least expensive service or supply considered professionally adequate treatment, as determined by Delta Dental, the plan's claims administrator.

Note that requesting a predetermination is not a requirement or considered a submission of a claim. Also, a predetermination of benefits is not binding.

expenses that aren’t covered

In certain situations, your Dental PPO benefits — or your eligibility for them — may be limited. For example, the plan doesn’t pay for the following:

- Charges for treatment or services that aren’t prescribed as medically necessary by a dentist or a doctor (although not all treatment or services prescribed by a dentist are considered covered charges).
- If alternate services or supplies are available for your treatment, charges you incur that exceed the least expensive service or supply considered professionally adequate treatment, as determined by Delta Dental, the plan’s claims administrator.
- Hospital room and board, and any associated hospitalization costs (such as facility-use fees).
- Charges for services rendered while the patient isn’t covered by the plan. (However, coverage is provided for charges for dentures, bridgework, crowns and inlays that are initiated/ordered while the patient is covered under the plan and that are delivered within 90 days after coverage ends, and coverage is provided for charges for root canal therapy if the tooth is opened while the patient is covered and treatment is completed within 90 days after coverage ends.)
- Charges you’re not required to pay or charges that wouldn’t be made if there were no coverage under this plan.
- Charges for which a claim for benefits isn’t filed within six months (by June 30) following the calendar year in which the service was provided.
- Dentures, bridgework, crowns and inlays ordered before the patient becomes covered under the plan.
- Extra sets or replacement of lost or stolen dentures, retainers or other appliances.
- Treatment or services provided by a government facility, doctor or dentist, or payable under a government plan or program, except as required by law.
- Experimental or investigative procedures, drugs or devices not generally recognized as being safe and effective, as determined by Delta Dental.

- Treatment of an injury or any dental condition that results from the patient's active participation in any of the following:
  - An insurrection or riot.
  - A crime, unlawful act or attempted crime.
  - War or any act of war (declared or undeclared) or international armed conflict or conflict involving armed forces of any international authority.
- Treatment of an injury or other loss that results from service in the armed forces of any government or international authority.
- Treatments provided by someone other than a dentist or doctor, except for treatment provided by a qualified technician or licensed hygienist under the supervision of a dentist or doctor.
- Cosmetic services or supplies, such as for teeth whitening.
- Porcelain facings on crowns or bridgework on back teeth.
- Training in or supplies used for dietary counseling, oral hygiene, plaque control, and tobacco counseling.
- Prescription drugs, and non-prescription drugs, vitamins or dietary supplements.
- Charges for Nitrous Oxide over age 12.
- Procedures, restorations or appliances to increase vertical dimension or to restore occlusion, except as covered under treatment for TMJ.
- Root canal therapy if the tooth has been opened and drained prior to the effective date of coverage under the Dental PPO.
- Crowns and restorations for any tooth not broken down by decay or traumatic injury.
- Orthodontic care, services or appliances received before the patient became covered under the Dental PPO except as noted under covered charges.
- Services and supplies for injuries sustained while engaged in any occupation for remuneration or profit or in connection with a disease or injury for which workers' compensation or similar benefits are payable, or in connection with a disease or injury for which benefits are payable under state or federal disability laws.
- Charges for partial procedures performed by a dentist, unless the partial procedure is a result of or due to additional services performed at the same visit, as determined by and at the sole discretion of Delta Dental.
- Charges for dental consultations, unless accompanied by a limited oral evaluation diagnostic code and limited to one per dentist per patient per 12-month period.
- Charges for congenital mouth malformations or skeletal imbalances (such as treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment.

- Treatment for malignancies or neoplasms, including biopsies.
- Services or appliances, crowns and fillings, for the purpose of restoring tooth structure lost from wear, including attrition, erosion or abrasion, or any other method of wear.
- Preventive restorations.
- Periodontal splinting of teeth by any method.
- Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
- Facial photographs.
- Genetic tests for susceptibility to oral disease and caries susceptibility tests.
- Viral cultures.
- Any procedure that is not a standard dental procedure or part of an enhanced benefit not currently covered under the Dental PPO.
- Removal of dental implants.
- Cancer screenings.
- X-ray duplications and 3-D x-rays
- Bite registrations or precision or semi-precision attachments
- Education or training in or supplies used for dietary or nutritional counseling, personal oral hygiene or dental plague control (including toothbrushes and dental floss), and tobacco counseling

Major services are limited as follows:

- Charges for a gold filling or crown are limited to the cost of a silver, porcelain or other filling, unless the tooth can't be restored with those materials.
- Charges for personalized restorations or characterizations of prosthetic appliances aren't covered.
- Charges for both a temporary and permanent prosthesis are limited to the charges for the permanent one. (To be covered, the prosthetic device must be necessary due to the loss of natural teeth or an unserviceable existing device.)
- Charges to replace gold fillings, crowns, bridgework or dentures less than five years old aren't covered.

If you or your dependent is injured by someone else's action or failure to act, or expenses are reimbursable under no-fault automobile insurance, benefits are provided under the plan only if you or your dependent agrees to reimburse the plan for all charges paid by the plan once damages are recovered from that person.

dental PPO claims

This section describes how to file a claim for Dental PPO benefits. You should be aware that Delta Dental has the right to request repayment if it overpays a claim for any reason.

- **Network coverage:** If you go to a network dentist when you need dental care, you don't have to file a claim form to get plan benefits. The plan pays your dentist directly. You pay any required coinsurance directly to your dentist.

- **Out-of-network coverage:** If you go to an out-of-network dentist for care, including a provider outside of the U.S., you have to file a claim form to receive reimbursement of covered expenses. You should file your dental claims as soon as you incur covered charges. Claim forms are available from the **Forms Library** on **hr2.chevron.com** or Delta Dental's website at www.deltadentalins.com/chevron.

When you fill out the claim form, use your full name and include your member ID number. Attach all the bills and receipts you received for the services and supplies provided, ask your dentist to sign the completed claim form and mail it to:

Delta Dental of California
PO Box 997330
Sacramento, CA 95899-7330

If you have questions about a submitted claim, wait at least three weeks after you send in the claim form and then call Dental Dental at 1-800-228-0513 (inside the U.S.) or 415-972-8300 (outside the U.S.) r, between 5 a.m. and 5 p.m. Pacific time, Monday through Friday.

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 Dental Dental within this time frame, benefits for that service will be denied.

The claims administrator will not reimburse third parties who have purchased or have been assigned benefits by dentists or other providers.

If your claim is denied, or if Delta Dental 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.

dental PPO claim review and appeals

The plan has a claim review process that is followed whenever you submit a claim for benefits. The sections below briefly describe how to file a claim for dental services that you believe are covered by the Dental PPO 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 in this summary plan description.

Initial Claim Review and Decision

When you file a claim, the claims administrator (Delta Dental 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 whether you submit a proper claim, including all necessary information.

Generally, all claims for the Dental PPO will be **post-service claims.** A post-service claim is any claim that does not require approval before you receive services, and that is filed for payment of benefits after care has been received.

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 Dental PPO Claims This chart describes the time limits for processing postservice dental claims.	
Time Limits	**Postservice Dental Claims**
Your deadline to provide additional information required by the plan to decide your claim	**45 days** after receiving notice that additional information is required.
Plan notice of initial claim decision	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.

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 above Time Limits for Processing Dental PPO Claims.

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:

- The reason(s) for the denial.
- 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 required by the plan).

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 UCCI and the time limits that apply.

Time Limits for Processing Dental PPO Appeals
This chart describes the time limits for processing appeals.

Time Limits	Postservice Dental Claims
Your deadline to file a first appeal	**180 days** after receiving the claim denial notice.
Plan notice of first appeal decision	**Not later than 30 days** after receiving an appeal, if the plan allows two levels of appeal.
Your deadline to file a second appeal	**90 days** after receiving the first appeal denial notice.
Plan notice of second appeal decision	**Not later than 30 days** after receiving a second appeal.

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.

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 relating to your claim for benefits.

Where to Send Your Appeal

The Chevron Dental Plan offers two levels of appeals. Send your appeals to:

Delta Dental of California
Attention: Appeal Department
PO Box 997330
Sacramento, CA 95899-7330

The claims administrator 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 and appeals.

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 above, Time Limits for Processing Dental PPO Appeals.

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.

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 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 civil lawsuit under Section 502(a) of ERISA following an adverse determination after completion of all levels of appeal 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.

Second Appeal

The Dental Plan allows two levels of 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. You must make this request for a second appeal in writing within the time limits noted in the chart above, *Time Limits for Processing Dental PPO Appeals* in this 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 Dental PPO Appeals* in this section.

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

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 state the reasons for the denial, including references to specific plan provisions upon which the denial was based and a statement of your right to file a civil lawsuit under Section 502(a) of ERISA.

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

If your 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.

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

Coordination of benefits is a feature used to determine how much the Dental PPO will pay when you or one of your dependents is covered by more than one group insurance plan. This feature is designed to prevent overpayment of benefits.

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.

If the Dental PPO is the secondary payer, plan benefits cannot be more than the contracted fees or Delta Dental's allowance, but not to exceed your responsibility under the primary plan.

Different coordination of benefits rules apply under different circumstances.

Coordination of benefits doesn't apply to medical or dental HMOs available to Chevron employees or to individual (nongroup) dental care insurance policies.

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

A plan other than your Dental PPO 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 the Dental PPO covers the individual as a dependent).
- It covers the individual as an eligible employee (while the Dental PPO covers the individual as an eligible retiree).
- It has covered the individual longer than the Dental PPO (if the other conditions in this bulleted list don't apply).

When you or a dependent is covered under both the Dental PPO and a Chevron Global Choice Plan, the Dental Plan will be the primary payer for services or supplies that are covered under both plans.

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

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

- In the case of domestic partnerships, the dental plan of the natural parent will be the primary payer.
- In the case of a married couple, the dental plan of the parent whose birthday falls earlier in the calendar year will be 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 will determine the order of benefits.

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

When parents are separated or divorced, or are 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.

mental health and substance use disorder plan

This section provides a description of the Mental Health and Substance Use Disorder Plan for you and your eligible dependents.

- Beacon Health Options

If you are an expatriate working in the U.S. and an eligible employee as described under Eligibility and Participation section of this SPD, then you are eligible to participate in the Mental Health and Substance Use Disorder Plan (also referred to as the MHSUD Plan).

overview

The Mental Health and Substance Use Disorder Plan (also referred to as the MHSUD Plan) provides confidential support for a wide range of personal issues — from everyday challenges to more serious problems. Beacon Health Options is the claims administrator for the MHSUD Plan.

- The MHSUD plan covers medically necessary and appropriate treatment as a result of a diagnosis of a mental illness or substance use disorder. It also covers treatment for mental health and substance use disorder concerns including services for depression, stress/anxiety, family or relationship issues, personal or work concerns, drug and alcohol recovery, dealing with domestic violence, eating disorders, and others.

- You're automatically covered if you're an eligible employee, even if you are not enrolled in the Global Choice Plan. If your dependents are enrolled in the Global Choice Plan, they're also automatically covered under this plan.
- Chevron pays for this coverage as part of its contributions toward your medical plan coverage.
- Beacon Health Options is the claims administrator for the plan and helps manage your benefits. Beach Health Options services include help with:
  - Locating providers in the network.
  - Answering questions about mental health and substance use disorder concerns.
  - Answering questions about your plan coverage.
  - Monitoring treatment progress.
  - Resolving problems or concerns you may have with your treatment.
- Beacon Health Options can be reached 24 hours a day, seven days a week at 1-800-847-2438.
- Chevron's Employee Assistance and WorkLife Services (EAP-WorkLife Services) is an internal consulting service that is staffed with licensed, certified mental health professionals who are familiar with Chevron policies and culture. EAP-WorkLife Services can:
  - Provide consultation on a broad range of issues from practical, everyday issues to more complicated personal and work-related concerns.
  - Listen to your concerns and, if you decide you'd like more help, they can help locate a Beacon Health Options network provider in your local area.
- The plan will pay 100 percent of covered charges when you use a provider that is in the Beacon Health Options network or when you obtain services outside the U.S. The Beacon Health Options network includes over 7,000 facilities and 49,000 behavioral health clinicians across the U.S. to assist you.
- When you use an out-of-network provider in the U.S., the plan generally reimburses you 70 percent for covered charges and the remaining cost is your responsibility. When you use services outside the U.S., you may use any provider. Your benefit is 100 percent of covered charges for services obtained outside the U.S. since there is no network outside the U.S.
- Whether you call Beacon Health Options or EAP-WorkLife Services, your privacy and that of your dependents will be respected. The nature of your call will be kept confidential, unless there's an immediate threat to life or health.

Mental Health and Substance Use Disorder Plan (MHSUD) is a grandfathered health plan under the Patient Protection and Affordable Care Act.

Chevron Corporation believes the Chevron Corporation Mental Health and Substance Use Disorder Plan (the MHSUD Plan) is a grandfathered health plan under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 1-888-825-5247 (610-669-8595 outside the U.S.). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

how the plan works

When You Use Services Inside the U.S.

- **The plan generally pays 100 percent of covered charges when you use a provider in the Beacon Health Options network** (also called a *network provider*). You do not have to file a claim form if you use a network provider in the U.S. To find providers in the U.S., call Beacon Health Options at-1-800-847-2438 or EAP-WorkLife services at 1-800-860-8205 (CTN 842-3333).

- **The plan generally pays 70 percent of covered charges when you use a provider in the U.S. that is not in the Beacon Health Options network** (also called an *out-of-network provider*). The plan benefits are based on billed charges and you are responsible for the remaining cost of services. If there are no Beacon Health Options providers near you, Beacon Health Options or EAP-WorkLife Services can help you locate a qualified clinician or facility in your area and review their credentials for you.

When You Use Services Outside the U.S.

The Beacon Health Options network is only available inside the U.S. So, if you go to a provider outside the U.S., you will be required to pay for the services when you receive them and submit a claim form to be reimbursed. Generally, the plan pays 100 percent of covered services obtained outside the U.S. Benefit reimbursement is based on billed charges for services obtained outside the U.S.

deductible

There is no deductible for this plan.

out-of-pocket maximum feature

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 whenever you use an out-of-network provider in the U.S.

Under this feature, 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. Note that your eligible out-of-pocket Global Choice Plan expenses will be combined with your eligible out-of-pocket mental health and substance use disorder expenses under the MHSUD Plan to determine if your out-of-pocket maximum has been reached.

Annual Out-of-Pocket Maximum Feature	
You Only	$2,000
You+Adult	$4,000
You+Child(ren)	$4,000
You +Family	$6,000

Each covered individual has a maximum out-of-pocket amount equal to the “You Only” out-of-pocket maximum amount. For the “You and Family” coverage category level, there is an overall maximum out-of-pocket amount for all covered participants. No more than the You Only amount can be applied for any one person to satisfy the You and Family out-of-pocket.

For example, if you and your eligible dependents are covered, your annual out-of-pocket maximum is met when the family’s accumulation of out-of-pocket costs reaches $6,000 with no more than $2,000 applied for each family member. Your family could meet the $6,000 maximum limit with charges of $2,000 for one member, $1,000 for a second member, $1,000 for a third member and $2,000 for a fourth member.

The following expenses do not count toward the out-of-pocket maximum amount and are not part of the 100 percent coverage you receive after reaching your out-of-pocket maximums:

- Charges in excess of covered charges.
- Charges for services, supplies or treatments that are not covered under the MHSUD plan.
- Charges for services, supplies or treatments from a network provider that are in excess of the network provider charges.
- Charges for services, supplies or treatments from an out-of-network provider that are in excess of the allowed charges, except for emergency services.

what the plan pays

This section provides information about the network and out-of-network benefits for covered services. The plan only pays benefits for covered charges for services, supplies, and treatment that are medically necessary and appropriate, as determined by Beacon Health Options, the claims administrator.

Mental Health Benefits

Inpatient Care – includes all 24-hour, medically intensive levels of care, including acute inpatient and detoxification. **Alternative Levels of Care** - includes all alternatives to acute inpatient and detoxification, including residential treatment, day treatment, partial hospitalization, structured outpatient programs and intensive outpatient programs.	
U.S. Network	100% of network provider charges.
U.S. Out of Network	70% of billed charges.
Outside the U.S.	100% of billed charges.

Inpatient services must meet medical necessity as determined by Beacon Health Options.

The plan provides coverage for inpatient treatment incurred while confined to a hospital or while being treated under an alternative level of care. Alternative level of care includes an intensive outpatient program or structured outpatient program which operates two to four days per week for at least three hours each day or partial hospitalization program which operates 3-5 days per week for 4-6 hours each day. This includes charges for prescription drugs if provided specifically as part of hospital inpatient or residential treatment center care.

The plan also provides coverage for day treatment which is generally less acute care where the patient is in a day or evening program. No plan benefits are paid for custodial care.

Outpatient Office Visits – includes individual, group, family, medication management.	
U.S. Network	100% of network provider charges.
U.S. Out-of-Network	70% of billed charges.
Outside the U.S.	100% of billed charges.

Outpatient services must meet medical necessity as determined by Beacon Health Options.

The plan provides coverage for outpatient office visits for the treatment of mental health problems. Included is treatment for serious conditions, such as depression, stress/anxiety, substance use disorder, eating disorders, as well as everyday challenges such as family stress, relationship difficulties and problems at work.

The Mental Health and Substance Use Disorder Plan doesn't cover prescription drugs for outpatient office visit treatment. If you're prescribed a drug as part of your outpatient treatment, you should check your coverage with Cigna Global Health (for prescriptions obtained outside the U.S.) and Express Scripts (for prescriptions obtained in the U.S.) to find out if your coverage under those plans can help pay for the drugs you need; otherwise, you'll be responsible for paying the full cost of prescribed outpatient medication.

Emergency Services	
U.S. Network	100% of network provider charges.
U.S. Out-of-Network	100% of billed charges.
Outside the U.S.	100% of billed charges.

If you or a dependent needs emergency care, you should go to the nearest hospital emergency room.

To qualify for plan benefits, emergency care must be required for the immediate diagnosis and treatment of a medical or mental condition that, if not treated immediately, could reasonably be expected to result in severe pain, permanent disability, serious medical complications, loss of life or danger to the patient or others.

Psychological Testing and Electroconvulsive Therapy	
U.S. Network	100% of network provider charges.
U.S. Out-of-Network	70% of billed charges.
Outside the U.S.	100% of billed charges.

The plan covers psychological testing and electroconvulsive therapy when used to diagnose a mental health disorder or when provided in conjunction with a diagnosed/covered psychiatric disorder. Psychological testing for learning disabilities is not covered.

Substance Use Disorder Benefits

Inpatient Care – includes all 24-hour, medically intensive levels of care, including acute inpatient and detoxification.

Alternative Levels of Care - includes all alternatives to acute inpatient and detoxification, including residential treatment, day treatment, partial hospitalization, structured outpatient programs and intensive outpatient programs.

U.S. Network	100% network provider charges.
U.S. Out-of-Network	70% of billed charges.
Outside the U.S.	100% of billed charges.

Inpatient services must meet medical necessity as determined by Beacon Health Options.

The plan provides coverage for inpatient treatment incurred while confined to a hospital or while being treated under an alternative level of care. Alternative level of care includes an intensive outpatient program or structured outpatient program which operates two to four days per week for at least three hours each day or partial hospitalization program which operates 3-5 days per week for 4-6 hours each day. This includes charges for prescription drugs if provided specifically as part of hospital inpatient or residential treatment center care.

The plan also provides coverage for day treatment which is generally less acute care where the patient is in a day or evening program. No plan benefits are paid for custodial care.

Office Visits – includes individual, group, family, medication management.	
U.S. Network	100% of network provider charges.
U.S. Out-of-Network	70% of billed charges.
Outside the U.S.	100% of billed charges.

Outpatient services must meet medical necessity as determined by Beacon Health Options.

The plan provides coverage for outpatient office visits for the treatment of substance use disorder problems.

The Mental Health and Substance Use Disorder Plan doesn't cover prescription drugs for outpatient office visit treatment. If you're prescribed a drug as part of your outpatient treatment, you should check your coverage with Cigna Global Health (for prescriptions obtained outside the U.S.) and Express Scripts (for prescriptions obtained in the U.S.) to find out if your coverage under those plans can help pay for the drugs you need; otherwise, you'll be responsible for paying the full cost of prescribed outpatient medication.

Emergency Services	
U.S. Network	100% of network provider charges.
U.S. Non-Network	100% of billed charges.
Outside the U.S.	100% of billed charges.

If you or a dependent needs emergency care, you should go to the nearest hospital emergency room.

To qualify for plan benefits, emergency care must be required for the immediate diagnosis and treatment of a medical or mental condition that, if not treated immediately, could reasonably be expected to result in severe pain, permanent disability, serious medical complications, loss of life or danger to the patient or others.

expenses that aren’t covered

In certain situations, Mental Health and Substance Use Disorder Plan benefits, or your eligibility for them, may be limited. For example, the plan doesn’t pay for the following:

- Treatment, supplies or services not prescribed by a clinician (although not all treatment or services prescribed by a clinician are considered covered charges).
- Services that aren’t considered medically necessary and appropriate, as determined by Beacon Health Options.
- Charges that you’re not required to pay.
- Charges in excess of allowed charges.
- Charges for which a claim for benefits isn’t filed within 365 days from the date on which a service was provided.
- Treatment provided by an immediate relative or someone who normally lives with you.
- Treatment, supplies or services furnished by a government facility or doctor, or payable under a government plan or program, except as required by law.
- Treatment of an injury that results from the patient’s active participation in any of the following:
  - An insurrection or riot.
  - A crime, unlawful act or attempted crime.
  - War or any act of war (declared or undeclared) or international armed conflict or conflict involving armed forces of any international authority.
- Treatment of an injury or other loss that results from service in the armed forces of any government or international authority.
- Treatment for a condition covered by workers’ compensation or other occupational disease law or sustained while working for compensation, profit or gain.
- Charges of a personal nature, such as the cost of newspapers, telephone, guest meals or rental of radios, television or bedside service tables, posture chairs and exercise equipment.
- Transportation costs.
- Charges that are reimbursed by an award or settlement that you receive from a third party for expenses for treating an injury or condition resulting from an act, or failure to act, of the third party.
- Experimental procedures, drugs or devices, as determined by Beacon Health Options in its sole discretion.
- Charges for services rendered while the patient isn’t covered by the plan.
- Custodial care.

- Educational rehabilitation or treatment of learning disabilities (including Pervasive Development Disorder and Autism Spectrum Disorder).
- Charges for broken appointments or completing or filing claim forms.
- Charges for treatment of physical illness, including, but not limited to, cirrhosis and neurological disorders.
- Charges for services, supplies or treatment that are covered charges under the Global Choice Plan (Expatriates in the U.S.) or another health care plan to which Chevron contributes including prescription drugs prescribed as part of outpatient treatment.
- Services furnished in response to a court order that aren't medically necessary and appropriate.
- Treatment of chronic pain, except for psychotherapy, biofeedback or hypnotherapy given in connection with a diagnosed psychiatric disorder.
- Aversion therapy.
- Treatment for personal growth or development.
- Treatment received to fulfill a requirement for professional certification.
- Charges for hypnotherapy, except when performed in connection with a diagnosed psychiatric disorder.
- Psychological testing, unless used to diagnose a psychiatric disorder or when given in conjunction with a diagnosed psychiatric disorder.
- Psychiatric or psychological examination, testing or treatments for obtaining or maintaining employment or insurance or relating to judicial or administrative proceedings.
- Private-duty nursing.
- Prescription drugs that are not prescribed as part of inpatient treatment under the MHSUD Plan.

how to file a mental health and substance use disorder claim

If you call Beacon Health Options or Chevron's Employee Assistance and WorkLife Services for a referral — and go to a Beacon Health Options network provider for care — you generally don't have to file a claim form to get your benefits. However, before your benefits can be paid, you must sign an authorization to release medical information. Beacon Health Options will send you an authorization form, or your provider may give you the form. Your provider will make arrangements with you if you need to pay for part of your treatment.

You may be billed directly by a provider if you live in an area where Beacon Health Options doesn't have any providers in its network and you receive treatment from another facility or provider that Beacon Health Options or Chevron's Employee Assistance and WorkLife Services refers you to. If so, to be reimbursed for treatment, you'll have to file a claim form with Beacon Health Options.

You also have to file a claim form if you use an out-of network provider for services. You can get a claim form from Beacon Health Options by calling 1-800-847-2438. Claim forms are also available from the **Forms Library** on **hr2.chevron.com**. To ensure timely payment, you should file your claim as soon as you can. If you don't file a claim within 365 days from the date on which you incur a covered charge, no plan benefits will be payable for that covered charge.

You'll receive written notice of the status of your claim within 30 days after Beacon Health Options receives it. If there are special circumstances that require more time, Beacon Health Options will advise you that more time is needed and will send its decision within 45 days of receiving the claim. If additional information is needed, 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. Note, different time limits apply for urgent care and pre-service claims as described in the Claim Review Process section.

If your claim is denied, or if Beacon Health Options 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. For more information, see the Claim Review Process section.

claim review and appeals

The plan has a claim review process that is followed whenever you submit a claim for benefits. The sections below briefly describe how to file a claim for mental health and substance use disorder services that you believe are covered by the MHSUD 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 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 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 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 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 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:

- 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 Beacon Health Options and the time limits that apply.

Time Limits for Processing MH/SA Appeals This chart describes the time limits for processing different types of appeals.			
	Types of Claims		
Time Limits	**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 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	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 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 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.

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 the claims administrator:

Beacon Health Options
Attn: Grievance and Appeals
PO Box 1851
Hicksville, NY 11802-1851

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 MHSUD 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 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 suit 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.

The claims administrator 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 and appeals.

Second Appeal

Beacon Health Options allows 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 MHSUD Appeals in this 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 MHSUD Appeals in this 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 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 of this book. 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 Beacon Health Options:

Beacon Health Options
Attn: Grievance and Appeals
PO Box 1851
Hicksville, NY 11802-1851

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

Coordination of benefits is a feature used to determine how much the Mental Health and Substance Use Disorder Plan will pay when you or one of your dependents is also covered under another group plan that provides coverage for treatment of mental health and substance use disorder problems. This feature is designed to prevent overpayment of benefits.

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). 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. If the Chevron Mental Health and Substance Use Disorder Plan is the secondary payer, the combined benefit from both plans won't total more than the Mental Health and Substance Use Disorder Plan's limit for the covered charges.

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 medical care plan maintained by Chevron.

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

A plan other than the Mental Health and Substance Use Disorder Plan will be the primary payer if it meets any
of the following conditions:

- It doesn't have a coordination of benefits rule.
- It covers the individual as an eligible employee or retiree (while the Mental Health and Substance Use Disorder Plan covers the individual as a dependent).
- It covers the individual as an eligible employee (while the Mental Health and Substance Use Disorder Plan covers the individual as an eligible retiree).
- It has covered the individual longer than the Mental Health and Substance Use Disorder Plan (if the other conditions in this bulleted list don't apply).

If the Chevron Mental Health and Substance Use Disorder Plan is the secondary payer, the combined benefit from both plans won't be more than the Mental Health and Substance Use Disorder Plan's limit for the covered charges.

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.

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

If you're covered by the Mental Health and Substance Use Disorder Plan and your spouse/domestic partner is covered by another group plan that provides coverage for treatment of mental health and Substance Use Disorder problems (and the other group 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 will be the primary payer.
- In the case of a married couple, the medical plan of the parent whose birthday falls earlier in the calendar year will be 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 will determine 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.

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 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 (if the first bullet does not apply).
- The plan of the parent or domestic partner without custody (or court-ordered financial responsibility) pays last (if the first and second bullets do not apply).

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.

chevron healthy you program

When you understand how healthy your heart is, you can take actions that can ultimately improve your overall wellness. By participating in this program you can learn about how your personal choices for diet, exercise, tobacco and work/life balance may affect your heart and health. Then you can choose goals, work with a health coach, and use a variety of online tools and resources that are personalized to you.

program overview

The Omnibus Health Care Plan permits wellness programs to be offered under the terms and conditions established by Chevron. As such, Chevron added the Healthy You Program as part of the Omnibus Health Care Plan.

This program is designed to help you understand your possible heart health risk factors, learn how your lifestyle choices may contribute to your heart health, and give you help making or keeping healthy habits. While the program focuses on heart health, it also provides additional resources designed to improve overall health and wellness. Healthy You can help you identify a plan and then put it into action. This program does not replace your regular visits to your health care provider. Your participation is voluntary.

The program includes the following services provided by WebMD:

- **Health Questionnaire.** The WebMD online health questionnaire is voluntary and confidential and takes approximately 15 minutes to complete. It will help you identify your health risk factors through a series of basic questions and your numbers. Using this information, the tool will give you a personal report highlighting your risk factors, goals and a suggested action plan to help you make healthy changes.

- **A Personal Action Plan.** After you complete the health questionnaire, you'll be presented with ideas and resources to reduce or manage your health risk factors (if any). These recommendations will be tailored to your personal situation based on the results of your health questionnaire.

- **A Personal Health Coach (By Phone).** After you take the health questionnaire, you'll have the option to be paired with a professional WebMD Health coach who will work with you and provide support. Coaches are not Chevron employees, they are WebMD employees. You meet with your coach by phone, at your convenience, and you direct the conversation around issues and goals that matter to you. Discussing the results of your health questionnaire is often a good starting point for your conversation.

- **The WebMD Health Assistant.** This is an interactive, online tool to helping you set, meet and track your health goals. After you select your goals, the Health Assistant lets you choose from a number of simple activities that become part of your weekly plan to support those goals. These activities have been created and developed by WebMD health coaches.

- **Online Education Materials and More Resources.** You'll have access to additional education materials and resources designed to support you in making healthy lifestyle changes. These resources are not medical advice or a substitute for seeking treatment or advice from your health care provider. Check them out on the WebMD Healthy You website.

Learn more about the Healthy You Program online at **hr2.chevron.com/healthyyou**. If you have questions about the Chevron Healthy You Program, send an email to **wellness@chevron.com** or call 925-842-8346 (CTN 842-8346).

eligibility

Employees

The Healthy You Program is available to expatriates on assignment in the U.S. if you are eligible to participate in the Global Choice Plan (Expatriates in the U.S.) and the Chevron Dental Plan. You don't actually have to be enrolled in either of these plans to participate; you just have to be eligible to participate in the plans, if desired.

Spouses and Domestic Partners

Your spouse or domestic partner can participate in Healthy You if eligible to be covered by you under the Global Choice Plan. Your spouse or domestic partner doesn't actually have to be enrolled in the plan to participate; they just have to be eligible to participate, if desired. Eligible spouses and domestic partners cannot use telephone coaching, but all other program tools and resources are available.

Children and Other Dependents

Your children and Other dependents age 18 years and older can participate in Healthy You if eligible to be covered by you under the Global Choice Plan. Your child or Other dependent doesn't actually have to be enrolled in the plan to participate; they just have to be eligible to participate, if desired. Eligible child or Other dependents age 18 years and older cannot use telephone coaching, but all other program tools and resources are available. Dependents under age 18 cannot participate at this time.

cost to participate

There is no fee for eligible employees and their eligible dependents for the health questionnaire or any of the other resources available through the Chevron Healthy You Program. However, program participants should consult with their health plan to determine if there is a cost for obtaining a blood test to screen for cholesterol and glucose. Chevron's health plans generally cover this screening at 100 percent as part of the preventive health benefit. Any out-of-pocket costs for this type of screening are the responsibility of program participants. Provision of blood pressure, cholesterol and glucose (blood sugar) numbers is not required to participate in the program, but the health questionnaire will provide a more accurate result if provided.

when participation starts

To start participation in the Healthy You Program, you must first complete the confidential health questionnaire. You are eligible to start participation on your hire date or on the first day you become eligible, whichever comes first.

How to Take the Health Questionnaire

You can complete the questionnaire at home or at work. If you complete the health questionnaire online, you will receive your results immediately.

Note that when you take the health questionnaire, you'll be asked to provide your personal health numbers, including your lab tests, so it's a good idea to have them ready. You don't need all of these numbers to take the health questionnaire or participate in the program, but you'll receive a more accurate result if you do.

- Go to **hr2.chevron.com/healthyyou**.
- Choose the program that applies to you: **Employees on Expatriate Assignment in the U.S.**
- Choose **Step 2: Health Questionnaire**.
- Follow the instructions on the screen to begin.
- Eligible dependents will need the employee's CAI to register on the site and create a username and password.

No access to the Internet?

The online health questionnaire is the preferred method of completion. If you don't have Internet access, you may call 1-925-842-8346 (CTN 842-8346) to request a paper health questionnaire. The paper health questionnaire is available only to employees; it is not available to eligible dependents. If you complete a paper version you will receive your results in one to two weeks, depending on your location.

when participation ends

Participation in this program will end if any of the following occurs:

- You or your dependent is no longer eligible. Participation ends on the last day of the month that eligibility ends.
- Chevron Corporation terminates the Global Choice Plan or a particular wellness program offered under the plan.
- 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 percent of the cost of continued health coverage).
  - 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).

Individuals eligible to participate in the Healthy You Program who have a qualifying event under the Continuation Coverage and COBRA Coverage provision of the Omnibus Health Care Plan (for example, a termination of employment) can continue participation in the Healthy You Program. Continuation lasts for up to the length of time described in the Continuation Coverage and COBRA Coverage section of this summary plan description or until the Healthy You Program is terminated, whichever comes first.

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 You Program, Health Decision Support, or Executive Physical Program.

who’s eligible for continuation coverage

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

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

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

qualifying events

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

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

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

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

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

Special Rule for Bankruptcy of the Employer

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

how to enroll

Chevron Must Give Notice of Some Events

Chevron has the responsibility to notify 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 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. 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:

- Survivor coverage.
- Continuation coverage.

The costs for 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 survivor coverage, or continuation coverage, generally, if you don't enroll in survivor coverage when you first become eligible, then you can only elect 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 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 survivor coverage with Chevron. 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 survivor coverage, your 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 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 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 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 survivor coverage after your death, as long as they do so within 31 days of your death.

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.

how to file a claim regarding eligibility to participate in the omnibus health care plan

If you have a question regarding your eligibility to participate in the Omnibus Health Care Plan (the plans described in this SPD are part of the Omnibus Health Care Plan), contact the HR Service Center at 1-888-825-5247, option 2 (610-669-8595 outside the U.S.). If you are not satisfied with the outcome, you can file a claim by following the procedures described in this section.

If you have been denied participation, 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 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 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 in the omnibus health care plan

If your claim for participation 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 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.

other plan information

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

administrative information

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

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 # 05721A009)

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

Chevron Corporation Dental Plan
(also referred to as the Dental PPO)
This plan is part of the Omnibus Health Care Plan.

Plan number: 560

Claims Administrator:
United Concordia Companies, Inc. | Dental Claims Department | P.O. Box 69420 | Harrisburg, PA 17106 | www.ucci.com

Type of Administration: Contract Administration

Type of Plan: Dental Benefit

Chevron Corporation Mental Health and Substance Use Disorder Plan
This plan is part of the Omnibus Health Care Plan.

Plan number: 560

Claims Administrator:
BeaconHealthOptions | P.O. Box 1290 | Latham, NY 12110
www.valueoptions.com

Type of Administration: Contract Administration

Type of Plan: Mental Health and Substance Use Disorder Benefits

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 U.S.) or prescription drug benefits provided by the Global Choice Plan, or VSP (for the vision program) regarding benefits or claims, then any legal action should be directed to the agent for service of legal process appointed by Cigna or VSP, as applicable.

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.

Plan Year

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

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 insurer will pay according to the terms of the insurance contract.

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.

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 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, Dental, Vision and Mental Health and Substance Use Disorder Plan 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-insured 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).

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.

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 following Chevron Corporation benefit plans, you're entitled to certain rights and protections under ERISA:

- Chevron Global Choice Plan (Expatriates in the U.S.).
- Chevron Corporation Prescription Drug Program.
- Chevron Corporation Vision Program.
- Chevron Corporation Dental Plan (also referred to as Dental PPO).
- Chevron Corporation Mental Health and Substance Use Disorder Plan.

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 Continuation Coverage and COBRA Coverage in this 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 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

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.

Notice About the Women's Health and Cancer Rights Act of 1998

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.

Mental Health Parity Act of 1996

Under the Mental Health Parity Act of 1996, as amended from time to time, health plan dollar limits for mental health cannot be lower than for other plan services. Limits may be imposed on the number of visits and days covered.

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 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 agree 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.

glossary

Some important terms related to your health plans.

Allowable Charge (Global Choice Plan)

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 or charges for behavioral health services covered under the Mental Health and Substance Use Disorder Plan.).

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.

Allowance (Dental Plan)

See Delta Dental's Allowance (Dental Plan).

Allowed Charges or Allowed Charge (Mental Health and Substance Use Disorder Plan)

Allowed charges are the basis for reimbursements that the plan will pay for necessary services and supplies that are prescribed by an out-of-network Clinician (although not all treatment and services prescribed by a Clinician are considered allowed charges) and that are covered by the plan. Allowed charges for services and supplies may vary from one geographic area to another and are based on a range of rates and fees that most Clinicians charge for the same service in that area and must be no more than the out-of-network Clinician normally charges for the service or supply. When reviewing charges to determine if they're covered under the plan's out-of-network coverage, Beacon Health Options doesn't attempt to set the amount that out-of-network Clinicians charge for needed services, nor does Beacon Health Options restrict your right to go to any Clinician you choose. However, Beacon Health Options does determine the allowed charge, and you're responsible for paying the difference between your out-of-network Clinician's charge and the allowed charge as established by Beacon Health Options.

For an employee who is an Expatriate in the U.S. and his enrolled dependents, the term "Allowed Charges" includes billed charges for an out-of-network provider. For services provided outside the U.S., "Allowed Charges" means billed charges.

Alternative Level of Care

A structured mental health and/or substance use disorder treatment program that:

- Is supervised by an M.D., D.O. or other practitioner who qualifies as a Clinician, and
- Is a facility-based, acute inpatient alternative, and
- Lasts from a few hours a few days per week, to 24 hours per day, to 7 days per week (for residential treatment, the patient may spend the night), and
- Includes a variety of treatment methods, which may include medical services, group and/or individual psychological, vocational and recreational therapies, and
- Is licensed, certified or approved by the state in which the program operates.

Alternative Level of Care includes acute inpatient treatment alternatives including day treatment, Residential Treatment Program, Structured Outpatient Program, Intensive Outpatient Program, and Partial Hospitalization Program.

Beacon Health Options

The Mental Health and Substance Use Disorder Plan's claims administrator, Beacon Health Options has a broad network of professional health care providers in many locations throughout the U.S Beacon Health Options reviews the treatment processes that these providers use and approves (or denies) proposed treatment plans. In addition, Beacon Health Options provides administrative services, such as paying providers and processing claims for benefits. More information about Beacon Health Options is available online at www.beaconhealthoptions.com

You can call Beacon Health Options for a referral to a network provider at any time day or night — or for customer service between 8 a.m. and 5 p.m. Pacific time, Monday through Friday. The toll-free telephone number is 1-800-VIP-CHEV (1-800-847-2438). If you're calling from outside the U.S., use the AT&T Direct Service code in the country you're calling from, and then dial 1-800-847-2438. Beacon Health Options claims should be mailed to P.O. Box 1290, Latham, NY 12110.

Beacon Health Options Network

The Beacon Health Options network includes over 7,000 facilities and 49,000 behavioral health clinicians across the U.S. to assist you. The network does not include providers or facilities outside of the U.S. Counselors from Beacon Health Options and Chevron's Employee Assistance and WorkLife Services provide referrals to network providers in your area when you or a dependent needs treatment for a mental health or substance use disorder problem. You can call Beacon Health Options at 1-800-VIP-CHEV (1-800-847-2438). (From outside the U.S., use the AT&T Direct Service code in the country you're calling from, and then dial 1-800-847-2438.)

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.

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.

Chevron's Employee Assistance and WorkLife Services (EAP-WorkLife Services)

A division of Chevron's medical staff that employs or contracts for the services of licensed counselors who provide crisis counseling, assessment and referrals for employees and dependents seeking treatment for mental health and substance use disorder problems. If you want to speak with a counselor from Employee Assistance and WorkLife Services about a personal problem, or if you need a referral to a provider in the Beacon Health Options network, you can call 1-800-860-8205 or 1-925-842-3333 (CTN 842-3333) anytime day or night.

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 vision care covered under the plan's vision program or outpatient prescription drugs covered under the plan's Prescription Drug Program or charges for behavioral health services covered under the Mental Health and Substance Use Disorder Plan). In addition, their staff in forms plan members which charges for health care benefits 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 **http://www.cignaenvoy.com**.

Clinician
A physician (M.D/D.O.), psychiatrist (M.D.), psychologist, social worker, counselor or nurse who is licensed or certified for independent practice by the proper authority of the state in which he or she practices and who is practicing within the scope of his or her license or certificate. In states where state law does not provide for licensure or certification, "social worker" means a professional certified by the National Board of Examiners in Clinical Social Work or the American Board of Examiners in Clinical Social Work.

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.

Contracted Fee(s)
The amount(s) a network provider agrees to accept as payment in full for covered services, supplies or treatment when Delta Dental has contracted for a specified rate for such service, supplies or treatment.

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 (Global Choice Plan)
Applies only to medical coverage. Refer to Section 12 of the Cigna Certificate of Coverage.

Covered Charges (Mental Health and Substance Use Disorder Plan)
Charges that the plan pays for mental health services and substance use disorder treatments that are medically necessary and appropriate while under the care of a clinician (although not all treatment or services provided by a clinician are considered covered charges) and that are covered by the plan.

Covered Charges (Dental Plan)
Charges that the plan pays for medically necessary services and supplies that are ordered by and while under the care and direction of a dentist (although not all treatment or services prescribed by a dentist are considered covered charges) and that are covered by the plan.

Network covered charges for those services and supplies are limited to the contracted fees between Delta Dental and the providers. See the definition for contracted fees in this section.

Out-of-network covered charges for those services and supplies are limited to Delta Dental's allowance for dental treatment that's either provided by a dentist or doctor or provided under the direction of a dentist or doctor. See the definition for Delta Dental's Allowance in this section.

Custodial Care
Care consisting of accommodations (including room and board and other institutional services) and services provided because of an individual's age or other mental or physical condition (rather than care for the treatment of illness or injury). Custodial care includes assisting the individual in the activities of daily living, such as eating, walking, taking medicine, bathing and changing bed positions, which could be provided safely and reasonably by persons without professional skills or training.

Custodial care also includes health-related services that don't seek to improve the patient's medical condition, or that are provided when the patient's medical condition is not changing.

Day Treatment Program
Care provided in a hospital, residential care or day treatment facility where the patient spends at least six hours a day in treatment at the hospital or facility but doesn't spend the night.

To qualify for Mental Health and Substance Use Disorder Plan benefits, the care must be part of a structured treatment program that satisfies all of the following requirements:

- It is supervised by an M.D. or a Ph.D. who qualifies as a clinician.
- It includes a variety of treatment methods, such as medical services, group and individual psychological, and vocational and recreational therapies.
- It is licensed, certified or approved by the state in which it operates, or is provided under the direction of a hospital or residential treatment program that's licensed, certified or approved by the state.

Delta Dental's Allowance (Dental Plan)
For out-of-network providers, Delta Dental's allowance may vary from one U.S. geographic area to another, is based on a range of rates and fees that most dentists and specialists charge for the same service in the same area, and must be no more than the out-of-network provider normally charges for the service or supply. When reviewing charges to determine if they're covered under the plan's out-of-network coverage, Delta Dental doesn't attempt to set the amount that out-of-network dentists and other providers charge for needed services, nor do they restrict your right to go to any dentist you choose. However, Delta Dental determines its allowance and you're responsible for paying the difference between

your out-of-network dentist's charge and the allowance established by Delta Dental. For services received outside of the U.S. the allowance is the billed amount.

Delta Dental of California (Delta Dental)

The claims administrator for the Dental PPO. They manage the plan's preferred provider organization and review, approve (or deny) and process claims filed by you or your provider. They can be reached by telephone at 1-800-228-0513 (inside the U.S.) or 415-972-8300 (outside the U.S.) between 5 a.m. and 5 p.m. Pacific time, Monday through Friday.

Depression and Alcohol Screening

Chevron offers you and your dependents a free, anonymous telephone screening service, which is available 24 hours a day, seven days a week. You can call 1-800-450-9549, respond to a series of questions by touching the keypad on your telephone, and within five minutes, learn whether your answers are consistent with depression or alcohol misuse. You'll also be given the telephone numbers for Chevron's Employee Assistance and WorkLife Services and Beacon Health Options, the company that administers the Mental Health and Substance Use Disorder Plan. Both offer confidential advice and referrals.

You can get this same information by accessing the **www.mentalhealthscreening.org/screening**. Use the password "*chevtex*."

Keep in mind that the telephone screening isn't intended to replace a formal assessment by a health care provider. It's just a tool you can use to see if you should get a referral to a provider and a more complete assessment.

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.

Eligible Provider (Mental Health and Substance Use Disorder Plan)

The term eligible provider refers to a Hospital, Alternative Level of Care or Clinician.

- A hospital — Refer to definition for Hospital
- **Alternative Level of Care** – Refer to definition for Alternative Level of Care
- A clinician — Refer to definition for Clinician

If you have a question about whether or not your provider is eligible, contact Beacon Health Options at 1-800-VIP-CHEV (1-800-847-2438).

Emergency Services

Services required to provide an immediate diagnosis and treatment of a medical or mental condition of sudden and unpredictable onset. Such condition must be marked by acute symptoms of sufficient severity which, in the absence of emergency medical attention, could reasonably be expected to result in severe pain, permanent disability, serious medical complications, loss of life or danger to self or others.

Experimental or Investigational Service

A medical, mental health, substance use disorder or other health care plan service, supply or drug that is any of the following:

- Not approved by the U.S. Food and Drug Administration or identified by the American Hospital Formulary Service or the U.S. Pharmacopoeia Dispensing Information as appropriate for use.
- Subject to review and approval by any institutional review board for proposed use.
- The subject of an ongoing clinical trial as defined by FDA regulations.
- Not demonstrated to be safe and effective for treatment, based on peer-reviewed medical literature.

Experimental and Investigative Services (Dental PPO Plan)

With respect to the Dental PPO Plan, the use of any treatment, procedures, facility, equipment, drug or drug usage, device, or supply which is not acceptable standard dental treatment of the condition being treated, or any such items requiring federal or other governmental agency approval when such approval has not been granted at the time the services are rendered, as determined by the Dental Plan Claims Administrator in its sole discretion.

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 Chevron's medical plan administrator, you must provide documentation every two years. If the disability is not chronic, Chevron's medical plan administrator will determine how frequently you will need to provide such documentation. For details, contact the HR Service Center.

Inpatient Treatment (Mental Health and Substance Use Disorder Plan)

Hospital, Residential Treatment Program, Alternative Level of Care, Intensive Outpatient Program, Structured Outpatient Program or similar treatment provided in a behavioral health facility.

Intensive Outpatient Program

A structured level of care in continuum between day treatment and traditional outpatient treatment which operates two to four days per week for a least three hours each day.

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 qualify 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.

Medically Necessary (Dental Plan)

This term generally refers to services or supplies that are prescribed by a dentist and accepted by the health care community as being reasonable and necessary for treatment of the condition. Medically necessary services can include those that are appropriate and necessary to diagnose, treat and care for a dental condition.

Even though a dentist may prescribe, order, recommend or approve a service or supply, it doesn't mean that it's medically necessary and appropriate. Delta Dental , the plan's claims administrator, determines if a service or supply is medically necessary.

Medically Necessary (Mental Health and Substance Use Disorder Plan)

Medically necessary services, supplies and treatments which include all of the following:

- Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (ICD-9 or DSM-IV) that threatens life, causes pain or suffering or results from illness or infirmity.
- Expected to improve an individual's condition or level of functioning.
- Individualized, specific and consistent with symptoms and diagnosis and not in excess of patient's needs.
- Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance use disorder care professionals or publications.
- Reflective of a level of service that is safe, where no equally effective, more conservative and less costly treatment is available.
- Not primarily intended for the convenience of the recipient, caretaker or provider.
- No more intensive or restrictive than necessary to balance safety, effectiveness and efficiency.
- Not a substitute for non-treatment services addressing environmental factors.

Even though a Clinician may prescribe, order, recommend or approve a service or supply, it doesn't mean that it's medically necessary. Beacon Health Options, the plan's claims administrator, determines if a service or supply is medically necessary.

Mental Health Services

Services provided by a Hospital, Clinician, or other licensed provider for the diagnosis or treatment of mental illness.

Multi-Source Drug

A medication that is available from multiple manufacturers and can include Brand-Name and Generic drugs depending on patient 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 53,000 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.

Network Provider
An Eligible Provider who is designated by Beacon Health Options as being part of its network of providers.

Network Provider Charges
The rate to be charged for Network Services provide by a Hospital, Clinician or other treatment facility when Beacon Health Options has negotiated a specific rate with the Network Provider.

Nonpreferred Brand-Name Drugs
Prescription Drug Program (Drugs Obtained Inside the U.S.)
Drugs that are covered by the Prescription Drug Program, which are not on Express Script's 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
Global Choice (Medical Coverage)
Global Choice (Drugs Obtained Outside the U.S.)
Prescription Drug Program (Drugs Obtained Inside the U.S.)
Mental Health and Substance Use Disorder Plan
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).

Outpatient Treatment
Treatment or care provided without an overnight stay in a medical facility.

Partial Hospitalization Program (PHP)
A structured therapeutic program either attached to a Hospital or free standing which operates 3-5 days per week for 4-6 hours each day. A PHP must be under supervision/oversight of a Medical Director/Licensed Program Director and must provide physician supplied medication management services. Staff must include physicians, nurses, psychologists and social workers and, if for substance use disorder, substance use disorder education and treatment. A PHP must have written admission and discharge criteria, individualized treatment plan and a full treatment program schedule, including individual therapy. A PHP must have documented patient/psychiatrist visit at least one time per week

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 — for example, 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 employment with Chevron before January 1, 2012, the applicable rules at the time of your termination will apply to whether you had a permanent service break.

Preferred Brand-Name Drugs
Prescription Drug Program (Drugs Obtained Inside the U.S.)
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 plan savings. For updated formulary information, visit www.Express-Scripts.com or call Express Scripts Member Services at 1-800-987-8368.

Prescription Drug Program ID Card
Prescription Drug Program (Drugs Obtained Inside the U.S.)
You will receive a separate Express Scripts prescription ID card to use every time you have a prescription filled at a network pharmacy. The card includes your Express Scripts member ID number, which is different from your medical plan ID number.

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.

Provider or Dentist (Dental Plan)
A practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

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

Residential Treatment Program or Residential Treatment Center

A program of treatment given in a facility that meets all of the following:

- Provides 24-hour residential care to patients who don't require acute care services or 24-hour nursing care.
- Provides structured mental health or substance use disorder treatment that includes medical supervision by a doctor (M.D./D.O.) and is staffed by a multidisciplinary team, which may include doctors (M.D.s, Ph.D.s), psychologists, social workers, registered nurses (R.N.s) and other health care professionals.
- Is licensed, certified or approved by the state in which the program operates.

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.

Specialty Pharmacy

Express Scripts Specialty Pharmacy, Accredo. A Specialty Drug must be ordered through the Specialty Pharmacy in order to be a covered charge.

Spouse

A person to whom you are legally married under the laws of a state or other jurisdiction where the marriage took place provided that your marriage is recognized as valid under the laws of your home country.

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 8 p.m. Pacific time, on Saturday from 7 a.m. to 8 p.m and on Sunday from 7am to 7pm Pacific Time. 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. Or you can access the VSP's website at **www.vsp.com/go/chevron**.