
# chevron medical PPO plan

## summary plan description

effective january 1, 2017

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This document describes the Chevron Corporation Medical Plan ("CMP") (also referred to as the Medical PPO Plan), as of January 1, 2017, that Chevron sponsors for eligible employees. It includes a description of the following components of this plan:

- Medical Coverage – Anthem Blue Cross (Anthem)
- Prescription Drug Program – Express Scripts

This information constitutes the SPD of the Medical PPO Plan as required by the Employee Retirement Income Security Act of 1974 (ERISA). These descriptions don't cover every provision of the plans. Many complex concepts have been simplified or omitted in order 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.

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

# update to addresses
## for benefits correspondence
## effective June 1, 2020

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

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

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

- **For health and welfare correspondence**
  Chevron Human Resources Service Center | PO Box 981901 | El Paso, TX 79998
- **For pension and QDRO correspondence**
  Chevron Human Resources Service Center | PO BOX 981909 | El Paso, TX 79998
- **For COBRA correspondence**
  Use the address included on your payment coupons

The addresses below may be referenced in this summary plan description and should be considered **no longer active and valid**.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

P.O. Box 18012
Norfolk, VA 23501

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

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

The QDRO Service Center
1434 Crossways
Chesapeake, VA 23320

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

# travel reimbursement
## for covered medical services

medical PPO 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 **Medical PPO 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

The Chevron Medical PPO Plan *currently* covers the cost of transportation and lodging only for certain emergencies and organ and tissue transplants. **Effective August 1, 2022, the Chevron Medical Plan now also includes an expanded travel expense reimbursement benefit for all covered medical 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 medical service under the Chevron Medical PPO Plan. 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 health situation.

- **The health care must be a covered medical service under the Chevron Medical Plan.**
  - If the related medical 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 medical benefits and is separate from this travel benefit plan provision.
  - Reimbursement for eligible travel expenses is only available under the Chevron Medical Plan. This plan provision *does not* apply to covered prescription drugs under the Chevron Prescription Drug Program or basic vision services under the Chevron Vision Program.
  - Travel expense reimbursement for organ and tissue transplant services are ineligible for reimbursement under this plan provision because they are already covered under the existing Organ and Tissue Transplant 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 medical 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 Chevron Medical PPO, 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 is *not* subject to the annual deductible.**
  While benefits for the covered medical service will continue to follow the Medical PPO Plan's normal deductible, coinsurance and copayment schedule, there is no separate deductible, coinsurance or copayment requirement for reimbursement of qualifying travel expenses.

- **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 medical 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 Medical PPO Plan 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 *medical care* for which you could have claimed a 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 medical 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 medical 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 medical 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 medical service.
  - The same limit applies whether the related medical 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 Anthem.
- Remember that the health service you or an enrolled dependent receives must be a *covered medical service* under the Medical PPO. If your coverage for the service is denied, you cannot request reimbursement for travel expenses. **For this reason, you are strongly encouraged to contact Anthem 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 medical service requires prior authorization, you will need to complete these normal benefit requirements to receive coverage for the service. If the medical service isn't covered, your travel expenses aren't covered.
- You'll need to make your own travel and lodging arrangements.
- Anthem 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 medical service.
- Keep in mind that you can't be reimbursed for qualifying travel expenses in *advance* of receiving the medical service, even if you've prepaid for air or train tickets and lodging.
- You are responsible for the payment of services rendered. Anthem 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 *medical* claim for the covered service, first

The related qualifying **medical claim** for the covered service must be on file with and approved by Anthem *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 medical claim for you. If the service was received from an out-of-network provider or facility, it is your responsibility to file a medical claim with Anthem. You can learn how to file a medical claim or check the status of a medical claim:

- From your Anthem website account at **www.anthem.com/ca**
- From the Anthem **Sydney Health** mobile app
- By calling Anthem at **1-844-627-1632**

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

You can submit a claim for reimbursement of qualifying **travel expenses** after Anthem has approved your claim for the related medical service. *Do not* use the standard medical claim form or the Anthem website to submit a travel benefit claim. You must use the **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 Anthem by check after processed. You can get the special travel benefit claim form:

- From the **Forms Library** on **hr2.chevron.com**.
- From your Anthem website account at **www.anthem.com/ca**
- By calling Anthem at **1-844-627-1632**

As a reminder, your signature on the **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 medical records by the provider to Anthem, if necessary.

# contact

Contact **Anthem** directly at **1-844-627-1632** to discuss claims, coverage under your plan, or to find a network provider.

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

# 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 Medical PPO Plan, the High Deductible Health Plan (HDHP) or the High Deductible Health Plan Basic (HDHP Basic), you are also automatically enrolled in prescription drug coverage through the Prescription Drug Program with Express Scripts. This change applies to the Prescription Drug Program for participants in the Medical PPO Plan, the High Deductible Health Plan (HDHP) and the High Deductible Health Plan Basic (HDHP Basic).*

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 Medical PPO Plan, the High Deductible Health Plan (HDHP) or the High Deductible Health Plan Basic (HDHP Basic), your **medical coverage** through Anthem already provides coverage for COVID-19 diagnostic testing when it is considered **medically necessary** and is **ordered by a health care provider or physician**. This means that, ordinarily, an over-the-counter, at-home COVID-19 diagnostic test would qualify for coverage through Anthem *only* when such test has been ordered by a physician.

**Effective January 15, 2022, you no longer need a physician's order to be reimbursed when you purchase covered at-home COVID-19 diagnostic tests through the Prescription Drug Program with Express Scripts.** [1] 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.

[1] If you *already* submitted a claim for reimbursement through your medical coverage with Anthem for a covered at-home COVID-19 diagnostic test before March 10, 2022, Anthem will process your reimbursement accordingly. Otherwise, all claims for tests purchased after January 15, 2022, outside of a network pharmacy or via mail order must be submitted to Express Scripts or they will be denied.

This temporary plan rule for at-home COVID-19 diagnostic tests 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 Anthem under the Chevron Medical PPO Plan, the High Deductible Health Plan (HDHP) or the High Deductible Health Plan Basic (HDHP Basic).

- 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 Anthem medical 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 follows:

- **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, 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. The system will not allow an order if a participant has exceeded the 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

When purchased from the *pharmacy* counter at a retail **network pharmacy**, 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.
- You purchase from another non-Express Scripts online retailer. (For example, Amazon.com or Walmart.com.)
- You purchase from a network pharmacy, 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 could not be verified at the time of purchase; therefore, you paid the full cost out-of-pocket and submitted a manual claim for reimbursement from Express Scripts at a later date.

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## how to submit a manual claim for reimbursement

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

### online

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

### by paper

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

### Find a network pharmacy, ask questions

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

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# new coverage for weight loss class of prescription drugs

chevron prescription drug program
effective january 1, 2022

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

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


## new coverage for weight loss class of prescription drugs


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

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

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

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

*(continued next page)*

## 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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# your right to receive continuation of care

## no surprises act

### effective january 1, 2022

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

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

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

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

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

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

# your rights and protections against surprise medical bills

## no surprises act

effective january 1, 2022

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

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## legislation that affects your benefits

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

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

# your rights and protections against surprise medical bills

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

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

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

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

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

## You are protected from balance billing for:

**Emergency services**

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

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

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

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

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

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

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

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

# 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 Medical PPO Plan, the High Deductible Health Plan (HDHP) or the High Deductible Health Plan Basic (HDHP Basic), you are also automatically enrolled in prescription drug coverage through the Prescription Drug Program with Express Scripts. This change applies to the Prescription Drug Program for participants in the Medical PPO Plan, the High Deductible Health Plan (HDHP) and the High Deductible Health Plan Basic (HDHP Basic).*

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 **network pharmacy** or an **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 an 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.

Similar to your medical coverage under the Medical PPO, HDHP or HDHP Basic plans, 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.

Participants enrolled in the Medical PPO Plan, the HDHP or the HDHP Basic, 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.

## Find a network pharmacy, ask questions

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

# online visits
## coverage for non-livehealth online providers
# medical PPO 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 **Medical PPO 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
## coverage for non-livehealth online providers

Where state laws allow, Anthem provides access to online visits through the LiveHealth Online service for participants of the Medical PPO Plan. To be covered, online visits must be accessed through the **LiveHealth Online** service with a LiveHealth Online provider from a smartphone, tablet or computer with a web cam.

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

Effective **January 1, 2021** the following rules apply to **online visits** under the **Medical PPO Plan**:

- Where state laws allow, the Medical PPO Plan coverage rules for Online Visits include covered charges for online visits from a **non-LiveHealth Online provider.**
- **Covered Charges** include medical consultations via telephone or using your network or out-of-network provider's virtual platform with a smartphone, tablet or computer with a webcam.
- Online Visits from a **non-LiveHealth Online provider** will follow the Medical PPO Plan rules for **Office Visits**, as follows:
  - **Network** 100% of contracted rates after a $25 copayment if a primary care physician, no deductible *or* after a $40 copayment if a specialist, no deductible.
  - **Out-of-Network** 60% of the maximum allowed amount after deductible.

# contact

Contact **Anthem** directly at **1-844-627-1632** to discuss claims, coverage under your plan, or to find a network provider. For medical-related questions and concerns, please contact your provider directly before visiting the office. **As always call 911 or go to the emergency room if you think you need care right away.**

# 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

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

# anthem total health total you program

effective january 1, 2021

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

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## Total Health Total You Program

This change applies to participants in the Medical PPO Plan, the High Deductible Health Plan (HDHP) and the High Deductible Health Plan Basic (HDHP Basic).

Anthem, the claims administrator for the Medical PPO, HDHP and HDHP Basic, may provide voluntary clinical support programs from time to time. These not only support your overall health and wellness, but also a wide array of clinical health conditions, such as asthma, diabetes, coronary artery disease and more.

Effective **January 1, 2021** Anthem's clinical support program, the **Total Health Total You Program**, will automatically be activated for all plan participants at no cost to you. Through existing technology and services – like the Anthem Engage app and the Primary Nurse Team – you'll receive targeted health communications and resource recommendations from Anthem that are tailored specifically to the health goals that are most important to you.

This change is primarily administrative, so there's nothing you need to do. However, you may notice more personalized guidance from Anthem in the form of preventive care reminders, provider recommendations, alternative care options, condition support and education, benefits information and other health program recommendations, strategies to reduce your health care costs, and more.

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

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

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 participants in the Medical PPO Plan, the High Deductible Health Plan (HDHP) and the High Deductible Health Plan Basic (HDHP Basic).*

When you enroll in the Medical PPO Plan, the High Deductible Health Plan (HDHP) or the High Deductible Health Plan Basic (HDHP Basic), 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**.

# 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.**

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## new rare conditions program

*This change applies to the Prescription Drug Program for participants in the Medical PPO Plan, the High Deductible Health Plan (HDHP) and the High Deductible Health Plan Basic (HDHP Basic).*

When you enroll in the Medical PPO Plan, the High Deductible Health Plan (HDHP) or the High Deductible Health Plan Basic (HDHP Basic), 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® .

# family planning and infertility services

## increase to lifetime maximum for infertility services

effective january 1, 2020

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

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## family planning and infertility services

This change applies to the Medical PPO Plan, the High Deductible Health Plan (HDHP) and the High Deductible Health Plan Basic (HDHP Basic)

Effective **January 1, 2020**, the lifetime maximum for infertility services has been increased from $5,000 to **$60,000**. Note that:

- There is no change to the specific services covered or the plans' deductible and coinsurance rates.
- Covered services previously accumulated toward the $5,000 lifetime maximum under the plan(s) prior to January 1, 2020 count toward the increased $60,000 lifetime maximum.
- Infertility services incurred prior to January 1, 2020 and after a participant previously reached the $5,000 lifetime maximum cannot be retroactively applied to the new $60,000 lifetime maximum.

| Family Planning and Infertility Services | |
|---|---|
| **Network** (Medical PPO Plan) | 80% of contracted rates after deductible. |
| **Out-of-Network** (Medical PPO Plan) | 60% of the maximum allowed amount after deductible. |
| **Network** (HDHP) | 80% of contracted rates after deductible. |
| **Out-of-Network** (HDHP) | 60% of the maximum allowed amount after deductible. |
| **Network** (HDHP Basic) | 70% of contracted rates after deductible. |
| **Out-of-Network** (HDHP Basic) | 50% of the maximum allowed amount after deductible. |

(Continued next page)

## **Family Planning and Infertility Services** (continued)

The plan helps pay covered charges for family planning and related services. These services include:

- The diagnosis and treatment of medical conditions that result in infertility, including expenses related to surgery and drug therapy.
- Artificial insemination.
- Vasectomy.
- Tubal ligation.
- Reversal of vasectomy or tubal ligation.
- Sperm preparation.
- Selection reduction in multiple births
- Abortions, either medically necessary or elective

The following services to facilitate a pregnancy are covered by the plan and are subject to an aggregate **$60,000** per person lifetime maximum benefit:

- In vitro fertilization.
- Embryo transfer.
- Gamete intrafallopian transfer.
- Zygote intrafallopian transfer.
- Tubal ovum transfer.

This lifetime maximum benefit aggregates the covered services accumulated while an eligible participant in the Chevron Medical PPO Plan, the Chevron High Deductible Health Plan (HDHP), the High Deductible Health Plan Basic (HDHP Basic), or any combination thereof.

Charges related to surrogate parents and charges incurred by a sperm or egg donor are not covered.

Included are physician-prescribed contraceptives that require insertion by a physician or significant physician follow-up, such as injectable contraceptives, morning-after pills, implants (such as Depo, Provera or Levonorgestrel), IUDs, diaphragms, other removable devices and related office visits.

Over-the-counter supplies are not covered.

Oral contraceptives are covered under the Prescription Drug Program.

# prescription drug program
## effective january 1, 2020

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**Update to the summary plan descriptions (SPD)**
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## managed prior authorization for xyrem

This change applies to the Prescription Drug Program for participants in the Medical PPO Plan, the High Deductible Health Plan (HDHP) and the High Deductible Health Plan Basic (HDHP Basic)

When you enroll in the Medical PPO Plan, the High Deductible Health Plan (HDHP) or the High Deductible Health Plan Basic (HDHP Basic), 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.

# COVID-19 coverage

## medical PPO plan

## effective march 27, 2020

*administrative clarification published as of january 1, 2022*

**Update to the summary plan descriptions (SPD)**
**All changes described in this SMM are effective March 27, 2020 unless otherwise indicated.**

The enclosed information serves as an official summary of material modification (SMM) for the **Medical PPO 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**.

The Medical PPO Plan has been amended as required by the Families First Coronavirus Response Act (FFCRA) effective March 18, 2020 *and* the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) effective March 27, 2020. **This March 27, 2020 SMM contains the current plan provisions as a result of FFCRA and the CARES Act and a new, temporary extension of online visit services. It also includes an administrative clarification published as of January 1, 2022, regarding medical necessity for COVID-19 testing covered charges.**

# COVID-19 testing

Effective **March 18, 2020** the following temporary plan rules apply under the Medical PPO Plan:

- The **network or out-of-network annual deductible** does not apply to covered charges related to medical care services and items purchased for COVID-19 testing as required by the Families First Coronavirus Response Act and the Coronavirus Aid, Relief, and Economic Security Act. As a reminder, the Medical PPO Plan has separate deductibles, one for *medical services* and the other for *prescription drug* costs. The coverage for COVID-19 testing only applies to the deductible for covered **medical** services.

- The Medical PPO Plan will pay **100%** of the provider's **contracted rate** for covered charges for medical care services and items related to the furnishing or administration of COVID-19 testing, or evaluation for purposes of determining the need for such testing, when you see a **network provider**.

- When you see an **out-of-network** provider for covered charges for medical care services and items related to the furnishing or administration of COVID-19 testing, or evaluation for purposes of determining the need for such testing, the Medical PPO Plan will pay **100%** of the cash price as listed by the out-of-network provider on a public Internet website, *or alternatively*, a lower price the Medical PPO Plan claims administrator negotiates for covered charges.

- In accordance with existing plan rules and federal law, except for preventive care, the Medical PPO Plan does not provide coverage for charges, services or supplies that aren't **medically necessary**. For purposes of COVID-19 testing, this means that the plan coverage described here applies to individualized diagnosis or treatment of COVID-19 or another health condition 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).

This temporary plan rule for COVID-19 testing will be in effect beginning on **March 18, 2020** until the end of the COVID-19 emergency period. (As of the date of this updated publication, the emergency period ends January 16, 2022, but is subject to change.)

# COVID-19 treatment

The following rules apply to treatment under the Medical PPO Plan:

- Covered charges related to medical care services and items purchased for COVID-19 treatment will be subject to the applicable **network** or **out-of-network annual deductible** for covered **medical** services.
- After meeting the applicable network or out-of-network annual deductible, the Medical PPO Plan will pay:
  - **80%** of the provider's **contracted rate** for covered charges relating to medical care services and items purchased for COVID-19 treatment when you see a **network provider**.
  - **60%** of the provider's **billed charges** for covered charges relating to medical care services and items purchased for COVID-19 treatment when you see an **out-of-network provider**.

# COVID-19 preventive service

The Medical PPO Plan currently provides coverage for preventive care services as required by the Patient Protection and Affordable Care Act and in accordance with guidelines based on recommendations from nationally recognized organizations, such as the U.S. Preventive Services Task Force. Effective **March 27, 2020** the Medical PPO Plan includes the following new rule for qualifying coronavirus preventive services:

- Any **qualifying coronavirus preventive service** will be considered eligible under existing preventive care coverage rules 15 business days after being designated as such.
- A qualifying coronavirus preventive service means an item, service or immunization that is intended to prevent or mitigate coronavirus disease 2019 and that is *either one* of the following:
  - An evidence-based item or service that has in effect a rating of *A* or *B* in the current recommendations of the United States Preventive Services Task Force.
  - An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

This updated publication notes that as of December 11, 2020, qualifying coronavirus preventive services are now available and included under the Medical PPO Plan's preventive care coverage. You can read more about the plan rules for this coverage in these SMMs:

- Medical Coverage: COVID-19 Preventive Services and Immunization Update (December 11, 2020)
- Prescription Drug Coverage: Coverage for Immunizations (February 15, 2021)

# online visits

As previously communicated, member cost sharing for LiveHealth Online visits will be waived for Medical PPO participants from March 19, 2020 through June 17, 2020. Anthem provides access to online visits through the LiveHealth Online service for participants of the Medical PPO Plan. **LiveHealth Online** is a safe and effective way for you to receive medical guidance, including guidance for COVID-19, from your home using a smartphone, tablet or computer with a web cam. You're encouraged to use this service when possible to help prevent the spread of infection and improve access to care.

## Online visits temporarily extended to include non-LiveHealth Online providers

Online visits are not covered outside of the LiveHealth Online provider group. However, in recognition of current physical distancing requirements during the COVID-19 pandemic, effective **March 18, 2020** the following temporary rules apply to **online visits** under the **Medical PPO Plan**:

- The Medical PPO Plan coverage rules for Online Visits will be extended to include covered charges for online visits from a **non-LiveHealth Online provider.**
- **Covered Charges** include medical consultations via telephone or using your network or out-of-network provider's virtual platform with a smartphone, tablet or computer with a webcam, where state laws allow.
- This temporary extension for online visits from a **non-LiveHealth Online provider** will be in effect beginning on **March 18, 2020** until the end of the COVID-19 emergency period. (As of the date of this updated publication, the emergency period ends January 16, 2022, but is subject to change.)
- Online Visits from a **non-LiveHealth Online provider** will follow the Medical PPO Plan rules for **Office Visits**, as follows:
  - **Network** 100% of contracted rates after a $25 copayment if a primary care physician, no deductible *or* after a $40 copayment if a specialist, no deductible.
  - **Out-of-Network** 60% of the maximum allowed amount after deductible.

# contact

Contact **Anthem** directly at **1-844-627-1632** to discuss claims, coverage under your plan, or to find a network provider. For medical-related questions and concerns, please contact your provider directly before visiting the office. **As always call 911 or go to the emergency room if you think you need care right away.**

# COVID-19 coverage

## medical PPO plan

## effective march 19, 2020

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**Update to the summary plan descriptions (SPD)**
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The enclosed information serves as an official summary of material modification (SMM) for the **Medical PPO 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**.

# COVID-19 testing

Effective March 19**, 2020** the following temporary plan rules apply under the Medical PPO Plan:

- The **network or out-of-network annual deductible** does not apply to covered charges related to medical care services and items purchased for FDA-approved COVID-19 testing. As a reminder, the Medical PPO Plan has separate deductibles, one for *medical services* and the other for *prescription drug* costs. The coverage for COVID-19 testing only applies to the deductible for covered **medical** services.

- The Medical PPO Plan will pay **100%** of the provider's **contracted rate** for covered charges relating to medical care services and items purchased for FDA-approved COVID-19 testing when you see a **network provider**.

- The Medical PPO Plan will pay **100%** of the provider's **billed charges** for covered charges relating to medical care services and items purchased for FDA-approved COVID-19 testing when you see an **out-of-network provider**.

# COVID-19 treatment

Effective March 19**, 2020** the following temporary plan rules apply under the Medical PPO Plan:

- Covered charges related to medical care services and items purchased for COVID-19 treatment will be subject to the **annual deductible** for covered **medical** services.
- After meeting the applicable network or out-of-network annual deductible, the Medical PPO Plan will pay:
  - **80%** of the provider's **contracted rate** for covered charges relating to medical care services and items purchased for COVID-19 treatment when you see a **network provider**.
  - **60%** of the provider's **billed charges** for covered charges relating to medical care services and items purchased for COVID-19 treatment when you see an **out-of-network provider**.

# online visits

**Member cost sharing for LiveHealth Online visits will be waived for Medical PPO participants from March 19, 2020 through June 17, 2020.** Anthem provides access to online visits through the LiveHealth Online service for participants of the Medical PPO Plan. **LiveHealth Online** is a safe and effective way for you to receive medical guidance, including guidance for COVID-19, from your home using a smartphone, tablet or computer with a web cam. You're encouraged to use this service when possible to help prevent the spread of infection and improve access to care.

# contact

Contact **Anthem** directly at **1-844-627-1632** to discuss claims, coverage under your plan, or to find a network provider. For medical-related questions and concerns, please contact your provider directly before visiting the office, or use the LiveHealth Online service. **As always call 911 or go to the emergency room if you think you need care right away.**

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

# COVID-19 immunization coverage updates

## medical PPO plan

effective december 11, 2020

**Update to the summary plan descriptions (SPD)**
**All changes described in this SMM are effective December 11, 2020 unless otherwise indicated.**

The enclosed information serves as an official summary of material modification (SMM) for the **Medical PPO 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**.

As of the writing of this benefit update, the cost of a COVID-19 immunization is often covered by local and federal government resources. This update describes medical coverage for qualifying coronavirus preventive services – including immunizations – in situations where public funding is not applicable.

## COVID-19 preventive service and immunization update

The Medical PPO Plan currently provides coverage for preventive care services as required by the Patient Protection and Affordable Care Act and in accordance with guidelines based on recommendations from nationally recognized organizations, such as the U.S. Preventive Services Task Force. As previously communicated, effective March 27, 2020 the Medical PPO Plan was updated to include coverage for qualifying coronavirus preventive services as part of the plan's existing preventive care coverage rules, when such services became available. **As of December 11, 2020, qualifying coronavirus preventive services are now available and included under the Medical PPO Plan's preventive care coverage.**

### What's a qualifying coronavirus preventive service?

A qualifying coronavirus preventive service means an item, service or immunization that is intended to prevent or mitigate coronavirus disease 2019 and that is *either one* of the following:

- An **immunization** that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
- An **evidence-based item or service** that has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.

## Temporary extension of coverage for out-of-network COVID-19 immunizations

As required by the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), effective **December 11, 2020** the following *temporary* rules apply to **qualifying coronavirus preventive services** under the **Medical PPO Plan**:

- When you see a **network provider**, the Medical PPO Plan will pay **100 percent** of the provider's **contracted rate** with no copayment, coinsurance or deductible for covered charges related to qualifying coronavirus preventive services.
- When you see an **out-of-network provider**, the **out-of-network deductible *will not* apply**, and the Medical PPO Plan will pay covered charges in an amount that is reasonable in comparison to prevailing market rates (or an alternative lower price, if negotiated) for qualifying coronavirus preventive services. Reasonable amounts are determined by Anthem, the claims administrator.
- These temporary rules for qualifying coronavirus preventive services will be in effect beginning on **December 11, 2020** until the end of the COVID-19 emergency period. As of this writing, the emergency period expires **April 21, 2021**, but is subject to change.

## A reminder about normal preventive care coverage rules

After the end of the COVID-19 emergency period, all of the normal Medical PPO Plan rules for preventive care shall apply to qualifying coronavirus preventive services. As a reminder, normal Medical PPO Plan preventive care rules are as follows:

- When you see a **network provider**, the Medical PPO Plan will pay **100 percent** of the provider's contracted rate with no copayment, coinsurance or deductible for covered charges related to preventive care services.
- When you see an **out-of-network provider**, the Medical PPO Plan will pay **60 percent** of the maximum allowed amount for covered charges related to preventive care services, and the annual **out-of-network medical deductible *will* apply**.

# contact

Contact **Anthem** directly at **1-844-627-1632** to discuss claims, coverage under your plan, or to find a network provider. For medical-related questions and concerns, please contact your provider directly before visiting the office. **As always call 911 or go to the emergency room if you think you need care right away.**

# 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 Medical PPO Plan, the High Deductible Health Plan (HDHP) or the High Deductible Health Plan Basic (HDHP Basic), you are also automatically enrolled in prescription drug coverage through the Prescription Drug Program with Express Scripts. This change applies to the Prescription Drug Program for participants in the Medical PPO Plan, the High Deductible Health Plan (HDHP) and the High Deductible Health Plan Basic (HDHP Basic).*

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**. 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 Medical PPO Plan, the High Deductible Health Plan (HDHP) or the High Deductible Health Plan Basic (HDHP Basic), 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. 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.

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# Update to the Summary Plan Description
## Effective March 1, 2019

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

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

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

This SMM applies to the following summary plan description:

- **Chevron Medical PPO Plan**

# Temporary Special Provision for Permian Basin Participants

Effective March 1, 2019, a temporary special provision will take effect under the **Chevron Medical PPO Plan (Medical PPO)** for plan participants 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 Medical PPO Plan rules, there are *different* deductible, coinsurance and/or copayment, and annual out-of-pocket maximum amounts for covered medical services 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 **medical** services on or after **March 1, 2019** from an **out-of-network provider** located in one of the **specified zip codes**, the Medical PPO Plan's **network** deductible, coinsurance and/or copayment, and annual out-of-pocket maximum amounts will *generally* be applied to the covered medical services received from the out-of-network provider. This temporary special provision only applies to covered medical services; it doesn't apply to covered prescription drug, basic vision or dental services.

## Who is eligible

### Eligible Permian participant

You're eligible for this temporary special provision if you're considered an eligible Permian participant. An **eligible Permian participant** is an eligible employee, eligible retiree or covered eligible dependent who is:

- Enrolled in the Medical PPO Plan at the time covered medical 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 medical 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 medical 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 medical services from an out-of-network provider who is *not* located in any of the specified zip codes. In these situations, the Medical PPO Plan's standard out-of-network rules and requirements will apply.

## How the special provision works

Under this temporary special provision, if you're an **eligible Permian participant** who receives covered medical 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

- As a reminder, the Medical PPO Plan has *separate* deductibles, one for medical services and the other for prescription drug costs. The temporary special provision only applies to the **deductible for covered medical services**.
- The Medical PPO Plan's **network deductible** will apply to covered medical services.
- **Allowable charges** you pay out-of-pocket for covered medical services will apply to the network deductible.
- All other Medical PPO Plan rules and requirements for the network deductible will apply to covered medical services.

### Coinsurance and copayments

- The Medical PPO Plan's **network coinsurance and copayment rates** will apply to the out-of-network provider's **billed amount** *or* **maximum allowed amount** for covered medical services, whichever is less. You will be responsible for your share of coinsurance or your copayment and any amount charged by the out-of-network provider in *excess* of the maximum allowed amount.
- All other Medical PPO Plan rules and requirements for network coinsurance and copayments will apply, including the current requirements to notify Anthem - the claims administrator - for specific procedures and services.

### Annual out-of-pocket maximums

- As a reminder, the Medical PPO Plan has *separate* out-of-pocket maximums, one for prescription drug costs and the other for medical, mental health and substance abuse services, combined. The temporary special provision only applies to the out-of-pocket maximum for **medical, mental health and substance abuse covered services, combined**.
- The Medical PPO Plan's **network annual out-of-pocket maximum** will apply to covered medical services received from an **out-of-network provider** located in one of the **specified zip codes**.
- All other Medical PPO Plan rules and requirements for the network annual out-of-pocket maximum will apply to covered medical services.

### Preventive care

The Medical PPO Plan includes 100 percent coverage with no copayment, coinsurance or deductible for certain preventive care services, as specified by the Affordable Care Act, when you see a network provider. Under the temporary special provision, 100 percent coverage for certain preventive care services will also apply to the out-of-network provider's **billed amount** *or* **maximum allowed amount**, whichever is less. This will only to eligible Permian participants who visit an **out-of-network** provider located in one of the **specified zip codes**.

### Maximum allowed amount

It's important to remember that covered medical services received from any out-of-network provider will continue to be subjected to Anthem's **maximum allowed amount** for that service. Allowed charges for the covered service will be applied to the to the Medical PPO Plan's **network** benefit provisions – deductible, coinsurance, copayment and out-of-pocket maximum – but you'll still be responsible for any charges *above* the maximum allowed amount.

### maximum allowed amount example

You're an eligible Permian participant and you receive covered medical services from an out-of-network provider located in one of the specified zip codes.

- Your provider charges **$250** for the service.
- Anthem's **maximum allowed amount** for that service in your area is **$200**.
- According to the temporary special provision, for this service, network coinsurance rates will be applied. This means you'll pay **20 percent** of **maximum allowed amounts**, and the plan will pay **80 percent**, after you've met your annual network deductible.
- You've already met your annual network deductible, so for this service you'll pay:

  20% (the network coinsurance rate) x $200 (maximum allowed amount) = **$40**

  *plus* **$50** (charges above the maximum allowed amount)

  You'll pay a total of **$90 out-of-pocket** and your Medical PPO Plan pays $160.

*This example is provided for illustration and education purposes only.*
*Your provider's service charge and your coinsurance rates or out-of-pocket costs will differ.*

## What's not changing

The temporary special provision only affects how your Medical PPO Plan's deductible, coinsurance, copayment and out-of-pocket maximum rules are applied for out-of-network covered medical 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 medical, prescription drug or basic vision coverage. The types of services the Medical PPO Plan covers remain the same.
- Alter the Medical PPO Plan's standard coinsurance or copayment rates for covered medical services from a network provider *or* an out-of-network provider who is *not* located in one of the specified zip codes.
- Apply to covered prescription drug (Chevron Prescription Drug Program), basic vision (Chevron Vision Program) or dental services.
- Apply to the Vision Plus Program.
- Alter the Medical PPO Plan's standard eligibility rules – who can enroll and who you can cover.

## Filing a claim for medical 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 Anthem to be reimbursed for covered medical services when you use an out-of-network provider. Contact Anthem at **1-844-627-1632** or log in to your account at **www.anthem.com/ca** to submit a claim.

## Anthem member ID card

If you are considered an eligible Permian participant, you will automatically receive a new medical ID card from Anthem at your mailing address. This is because your group number will change as an eligible Permian participant. It's important that you use your new Anthem ID card with the new group number for covered medical services on or after March 1, 2019. Contact Anthem at **1-844-627-1632** if you have questions about your new ID card. You *will not* receive a new ID card from Express Scripts for prescription drugs or VSP for basic vision coverage as these services are not affected by the temporary special provision.

## 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 | |

# 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 fee for insufficient funds

effective January 1, 2019

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

The enclosed information serves as an official summary of material modification (SMM) for this plan. Please keep this information with your other plan documents for future reference. You can access the summary plan descriptions for your benefits at **hr2.chevron.com** 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.

# 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.**

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# 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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# prescription drug program
## advanced opioid management program
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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# prescription drug program

## advanced opioid management program

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

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

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

### have questions?

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

## what this means when you are prescribed an opioid medication

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

### quantity limits

| | |
|---|---|
| ✓ Prevention of patient overuse | **Morphine Equivalent Dose (MED) based quantity limit**<br>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**<br>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**<br>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:<br>• 15 patches for 30 days at retail.<br>• 45 patches for 90 days at mail. |

### prior authorization

| | |
|---|---|
| ✓ Patient safety measure | **Long Acting Opioid**<br>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**<br>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. |

# medical PPO plan

The **Medical PPO Plan** is a preferred provider organization (PPO) health plan, so you can choose to see any provider you want. However, remember that you pay more out-of-your pocket if you visit an out-of-network provider. The Medical PPO Plan includes **medical** coverage with Anthem Blue Cross (Anthem) and **prescription drug** coverage with Express Scripts. You're also automatically enrolled in the Vision Program for **basic vision** coverage with VSP, and the Mental Health and Substance Abuse Plan with Beacon Health Options. The Medical PPO Plan changes described in this section take effect on January 1, 2018.

## new benefits and features for 2018

The Medical PPO Plan includes the following new benefits features effective January 1, 2018. See Page 15 for further details.

- Hearing aid coverage for adults.
- New condition-specific prescription drug programs.

## monthly premium

Chevron will currently continue to share the monthly cost of coverage — the premium — with eligible employees.

**Employee monthly premium**

**$138** You only
**$276** You + One adult
**$235** You + Child(ren)
**$373** You + Family

**Employee monthly premium if wellness credit obtained**

**$75.50** You only
**$213.50** You + One adult
**$172.50** You + Child(ren)
**$310.50** You + Family

There's still time to receive this reduced monthly premium in 2018. The deadline to qualify for the 2018 Wellness Credit is October 27, 2017. See Page 20

## annual deductibles

The Medical PPO Plan has separate deductibles, one for **medical services** and the other for **prescription drug costs**. There is no deductible for **mental health and substance abuse** services.

### Covered prescription drugs deductible

The Medical PPO Plan prescription drug deductible is not changing in 2018; this information is provided for your reference only. The prescription drug deductible is the same whether you use a network or out-of-network provider. As a reminder, mail-order prescriptions are *not* subject to the annual deductible.

| Coverage category | Network or Out-of-network |
|---|---|
| You Only | **$150** |
| You + One Adult*<br>You + Child(ren)*<br>You + Family* | **$300** |

*Each covered individual has a maximum deductible equal to the **You Only** amount.

### Covered medical services deductible

The Medical PPO Plan deductible for covered medical services is not changing in 2018; this information is provided for your reference only. There are different deductible amounts for covered **medical** services depending on if you see a network or an out-of-network provider. Amounts paid for covered medical services provided by a network provider also count toward the out-of-network annual deductible. Amounts paid for covered medical services provided by an out-of-network provider also count toward the network annual deductible.

| Coverage category | Network | Out-of-network |
|---|---|---|
| You Only | **$1,000** | **$2,000** |
| You + One Adult* | **$2,000** | **$4,000** |
| You + Child(ren)* | **$2,000** | **$4,000** |
| You + Family* | **$3,000** | **$6,000** |

*Each covered individual has a maximum deductible equal to the **You Only** amount.

# hearing aid coverage for adults
effective january 1, 2018

human energy. yours.™

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

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

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

## hearing aid coverage for adults

Under current plan rules, coverage for hearing aids is only available to children under age 26. Effective January 1, 2018, the Medical PPO Plan, the High Deductible Health Plan (HDHP) and the High Deductible Health Plan Basic (HDHP Basic) will expand hearing aid coverage to **all plan participants**, including adults. Effective January 1, 2018, the plan pays covered charges, after the deductible, for hearing aids, including bone anchored hearing aids (BAHA) when medically necessary. Hearing aids are covered up to a maximum of **$5,000 once every 4 years**. Cochlear implants in adults are governed by a separate plan rule and are not affected by this plan change.

### Medical PPO Plan

| | |
|---|---|
| **Network** | 80% of contracted rates after deductible. |
| **Out-of-network** | 80% of the maximum allowable amount after deductible. |

### High Deductible Health Plan (HDHP)

| | |
|---|---|
| **Network** | 80% of contracted rates after deductible. |
| **Out-of-network** | 80% of the maximum allowable amount after deductible. |

### High Deductible Health Plan Basic (HDHP Basic)

| | |
|---|---|
| **Network** | 70% of contracted rates after deductible. |
| **Out-of-network** | 70% of the maximum allowable amount after deductible. |

**Hearing aids**
Coverage includes the hearing aid device and fitting. Batteries and routine maintenance of the device are not covered.

**Bone Anchored Hearing Aids (BAHA)**
Coverage for BAHA includes the actual hearing device as well as the surgery* to attach or remove the device. Coverage for BAHA is limited to the following conditions:

- Craniofacial anomalies where abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity exists that would not be adequately remedied by a wearable hearing aid.

*The surgery is covered by a separate Surgical benefit under the plan. See the **Surgical** heading in the **What the Plan Pays** section in the **Medical coverage** chapter of your plan's summary plan description available online at **hr2.chevron.com**.

# 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**

# table of contents

# benefit contact information

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

## Human Resources Service Center (HR Service Center)

**Why contact this administrator**

- Enroll in this plan.
- Enroll in or learn about COBRA continuation coverage for health plans.
- Make open enrollment elections for this plan.
- Ask about your or your dependents' eligibility to participate in this plan.
- Report qualifying life events – such as a marriage, divorce, birth or death.
- Change your address with Chevron and your benefit plan(s).
- Designate beneficiaries for your Chevron benefits.
- Report a death.
- Enroll in Chevron survivor health coverage.
- Register your domestic partner.
- Request an *Intent to Retire* package.
- Request a printed copy of summary plan descriptions (SPD).

**COBRA and Continuation Coverage for Chevron Health Plans**

The HR Service Center is also the administrator of COBRA and continuation coverage for Chevron health plans. Contact the HR Service Center to:

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

**Phone information**

- 1-888-825-5247
- You'll need your Personal Identification Number (PIN) when you call the HR Service Center. If you don't know or forget your PIN, hold the line each time you are prompted to enter it until you are presented with further options and instructions.

## Chevron Benefits HR2 Website

**Why access this website**

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

**Website information**

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

## Benefits Connection Website

- **Benefits Connection** website for personal information and conduct certain transactions, such as changing your address, updating your beneficiaries, view your current enrollments and costs, enroll in Chevron benefits, enroll in COBRA coverage for health plans, make benefit changes or make open enrollment elections.
- As an employee, go to **hr2.chevron.com** and click the **Benefits Connection** link.
- After you leave Chevron, go to **hr2.chevron.com/retiree** and click the **Benefits Connection** link.
- If you have access to a Chevron workstation connected to the GIL computing network, you can use the automatic login feature; you don't need a password to access the Benefits Connection website.
- If you don't have access to a Chevron workstation connected to the GIL computing network, you will need to enter your Benefits Connection User ID and Passcode; automatic login is not available. Follow the instructions on the Benefits Connection login screen if you need to register to use the website or if you don't remember your User ID and Passcode.

## Summary Plan Descriptions

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

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

## Anthem Blue Cross (Anthem)

Claims administrator for the medical coverage under the Medical PPO. Anthem also manages the certification of chronic disabilities in dependents for all Chevron health plans.

**Why contact this administrator**

- For detailed information about the medical plan services this plan covers and does not cover.
- To file a claim or check the status of a claim.
- To locate a network provider.
- To get information about your current deductible and out-of-pocket maximum amounts.
- To request an ID card.
- To certify or manage the chronic disability status of a dependent.

**Plan identification information**

- **Plan Group Number:** 174209
- **Network Code for Online Provider Searches:** CCV
- **Network Name:** National PPO

**Phone information**

- 1-844-627-1632

**Website information**

- **www.anthem.com/ca**
- To search for a network provider online as a Member *without* logging in, enter your **ID number** or **CCV**.
- To search for a network provider online when you're *not* a Member, *do not search as a Guest*. Answer the basic questions on the screen and enter **CCV**.

**Mobile app**

- Anthem Anywhere – Google Play and iTunes

## Express Scripts

Prescription Drug Coverage (Prescription Drug Program)

Claims administrator for prescription drug coverage under the Medical PPO.

**Why contact this administrator**

- For detailed information about the prescription drugs this plan covers and does not cover.
- To file a claim or check the status of a claim.
- To locate a network pharmacy.
- To manage your home delivery.
- To get information about your current deductible and out-of-pocket maximum amounts.
- To request an ID card.

**Plan identification information**

- **Plan Group Number:** CT1839
- **Network Name:** National Plus Network

**Phone information**

- 1-800-987-8368

**Website information**

- www.express-scripts.com

**Mobile app**

- Express Scripts Mobile App – Google Play, Apple iTunes, Amazon App, Windows Phone

## VSP Vision Services (VSP)

Chevron Vision Program

Claims administrator for basic vision coverage under the Chevron Vision Program.

**Why contact this administrator**

- For detailed information about the basic vision services this plan covers and does not cover.
- To file a claim or check the status of a claim.
- To locate a network provider.

**Plan identification information**

- **Plan Group Number:** 30021085
- **Network Name:** VSP Choice

**Phone information**

- 1-800-877-7195 (Inside the U.S.)
- 1-916-851-5000 (Outside the U.S.) - press '0' for operator assistance

**Website information**

- chevron.vspforme.com

## Towers Watson OneExchange (OneExchange)

**Why contact this administrator**

- When you reach an enrollment milestone for retiree health benefits.
- Ask or learn about your or your eligible dependents' post-65 health benefit choices, costs, and eligibility for the individual plans.
- Enroll in post-65 individual health coverage offered to Chevron eligible retirees and their eligible dependents.

**Phone information**

- 1-844-266-1392 (Inside the U.S.)
- 1-801-994-9805 (Outside the U.S.)
- 5 a.m. - 6 p.m. Pacific time (7 a.m. - 8 p.m. Central time)

**Website information**

- Go to **hr2.chevron.com/retiree** and click the **OneExchange** link from the top banner.
- You can also go directly to **https://medicare.oneexchange.com/chevron**.
- On this website you can manage your Retiree HRA Plan account and reimbursement claims and also access individual health coverage information and decision-making support tools.

# chevron medical PPO plan
## overview of the plan

The Chevron Corporation Medical Plan, hereafter referred to as the Medical PPO, is a preferred provider organization (PPO) medical plan that Chevron sponsors for eligible employees. This plan includes the following components:

- Medical coverage, with Anthem Blue Cross(Anthem) as the claims administrator.
- Prescription drug coverage, with Express Scripts as the claims administrator.

In addition, if you enroll in the Medical PPO you are also automatically enrolled in the Chevron Vision Program for basic vision coverage with VSP.

U.S.-payroll resident expatriates and non-U.S.-payroll expatriates working in the United States are not eligible for the Medical PPO. U.S.-payroll resident expatriate employees may be eligible to participate under the Global Choice Plan (U.S.-Payroll Expatriates), described in the **Global Choice Plan (U.S.-Payroll Expatriates)** summary plan description. Eligible expatriate employees working in the United States are eligible to participate under the Global Choice Plan (Expatriates in the U.S.), as described in the **Global Choice Plan (Expatriates in the U.S.)** summary plan description. Go to **hr2.chevron.com** for both of these summary plan descriptions.

**Note:** Depending on where you live, you may be eligible for a medical health maintenance organization (HMO) plan. If you choose an HMO for your medical coverage, review the *Medical and Dental HMO* summary plan description. That SPD gives you information about eligibility, participation and your legal rights. For information about covered services or a list of HMO providers, contact your HMO.

# medical PPO overview

- The plan is a preferred provider organization (PPO) plan. This means that the plan has a network of health care providers available in many locations. Higher benefits are paid when you receive care from a network provider. You always have the option of using an out-of-network provider, but plan benefits are lower if you do.

- You generally must satisfy the deductible with money out of your own pocket before many plan benefits can be paid.

- Certain preventive care services as specified under the Affordable Care Act (ACA) are covered at 100% when you see a network provider and not subject to the Medical PPO Plan deductible.

- A feature of the plan is the out-of-pocket maximum, which limits your out-of-pocket costs.

# eligibility

## Additional Eligibility Requirements for this Benefit

This section of this summary plan description provides important information about who's generally eligible to participate in Chevron's health benefits. To be eligible to participate in this benefit, you and your dependents must meet all the requirements of an eligible employee and an eligible spouse, domestic partner, child or other dependent as described in this section, **and** you and your dependent must *also* satisfy these additional eligibility requirements or restrictions:

- If you enroll for coverage under a Chevron medical plan, 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).
- U.S.-payroll expatriates are only eligible for the **Global Choice Plan (U.S.-Payroll Expatriates)** while on expatriate assignment. U.S.-payroll resident expatriates should refer to the **Global Choice Plan (U.S.-Payroll Expatriates)** summary plan description for information about health coverage.
- Non-U.S.-payroll expatriates working in the United States are only eligible for the **Global Choice Plan (Expatriates in the U.S.)** while on expatriate assignment. Non-U.S.-payroll expatriates should refer to the **Health Benefits for Expatriates in the U.S.** summary plan description for information about health coverage.
- If you're eligible to receive benefits from the Chevron International Healthcare Assistance Plan (IHAP), you're not eligible for the Medical PPO Plan.

## Eligible Employee

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

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

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

- You're not on the Chevron U.S. payroll, or you're compensated for services to Chevron by an entity other than Chevron — even if, at any time and for any reason, you're deemed to be a Chevron employee.
- You're a leased employee or would be a leased employee if you had provided services to Chevron for a longer period of time.
- You enter into a written agreement 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 a professional intern.

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

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

Chevron Human Resources Service Center
P.O. Box 18012
Norfolk, VA 23501
1-888-825-5247

## Eligible Spouse

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

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

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

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

## Eligible Domestic Partner

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

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

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

2. You live in California and meet all of the requirements of the California Family Code section 297 definition of a domestic partner, including the requirement to have registered your domestic partner with the Secretary of State's office. For more information, visit the California Domestic Partnership website at **www.sos.ca.gov/registries/domestic-partners-registry/**.
3. You live in another state (such as Colorado, District of Columbia, Hawaii, Illinois, Maine, Nevada, New Jersey, Oregon, Washington, Wisconsin and others) that recognizes civil unions or state-recognized domestic partnerships and have entered into a civil union or state-recognized domestic partnership and reside in that state.
4. You and your partner have entered into a civil union in a state that recognizes civil unions, but reside in a state where that civil union is not recognized.
5. You meet other criteria set forth in the *Chevron Affidavit of Domestic Partnership*.

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

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

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

## Eligible Children and Other Dependents

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

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

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

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

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

Incapacitated children over age 26 can be added to coverage only if they were disabled before age 26 and had other health care coverage immediately before being added as a dependent under a Chevron plan. You will be required to provide documentation of both conditions. Incapacitated children added after age 26 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 important information about participation in the Medical PPO.

## 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 |
|---|---|---|
| **Medical PPO**<br><br>Includes prescription drug coverage. You're also automatically enrolled in the Chevron Vision Program for basic vision coverage | You can enroll yourself and your eligible dependents at any of the following times:<br>• During your first 31 days on the job, if you're eligible.<br>• During open enrollment.<br>• Within 31 days of a qualifying life event.<br><br>**Note:** To be eligible for the Mental Health and Substance Abuse Plan, your dependents must be enrolled in one of the Chevron-sponsored medical plans. | To enroll, contact the HR Service Center. Be sure to complete and turn in any forms sent to you with your confirmation statement.<br><br>Before a dependent's enrollment is processed, you may be required to provide proof of his or her eligibility (that is, a marriage license, a birth certificate or adoption papers). In addition, before you can enroll your domestic partner for medical plan coverage, you must file a notarized *Chevron Affidavit of Domestic Partnership (F-6)* form. To request a form, call the HR Service Center.<br><br>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). |
| **Before-Tax Contribution Plan** | If you enroll in a health plan to which Chevron contributes, you're automatically enrolled to have before-tax deductions for any medical and dental plans. | If you enroll in a health plan to which Chevron contributes, you're automatically enrolled to have before-tax deductions, unless you elect not to enroll in before-tax deductions. If you want to decline before-tax participation before your health plan coverage begins, contact the HR Service Center. |

## Before-Tax vs. After-Tax Contributions

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

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

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

Making before-tax contributions may lower your Social Security benefits slightly if you earn less than the Social Security wage base (which is $127,200 in 2017 and may change each year). However, the advantages of current tax savings may outweigh the possible reduction in your Social Security benefits at retirement. If you earn more than the Social Security wage base, you won't save any Social Security tax by making before-tax contributions, and your future Social Security benefits won't be reduced.

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

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

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

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

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

- You live in California and meet all of the requirements of the California Family Code section 297 definition of a domestic partner, including the requirement to have registered your domestic partner with the Secretary of State's office. For more information, visit the California Domestic Partnership website at **www.sos.ca.gov/registries/domestic-partners-registry/**. If you reside in California, you will be exempt from imputed income if you report that your domestic partner meets the state's requirement of a tax dependent and you report that you have registered your domestic partner or with the Secretary of State.

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

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

## Making Changes

You can make changes to some of your benefit elections at any time. Other changes can be made only during open enrollment (which is typically held during a two-week period each fall) or when there's a qualifying life event during the year. If you want to change or cancel coverage, contact the HR Service Center. The following chart includes a brief explanation of the changes you can make under coverage related to the Medical PPO.

| Plan | Types of Changes |
|---|---|
| **Medical PPO**<br>Includes prescription drug coverage. You're also automatically enrolled in the Chevron Vision Program for basic vision coverage. | • You can change your medical plan elections only:<br>—During open enrollment. Changes take effect the following January 1.<br>—During the year if you or a dependent qualify for special enrollment or have a qualifying life event.<br>• If you pay for your coverage on an after-tax basis, however, you can cancel your coverage or drop dependents from coverage at any time. |
| **Before-Tax Contribution Plan** | • You can change the tax status of your health plan contributions (before-tax to after-tax or vice versa) during any open enrollment. Changes take effect the following January 1. You can't otherwise change your plan elections unless there's a qualifying life event. |

**Midyear Changes**

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

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

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

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

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

## Special Enrollment Rights Under HIPAA

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

If you are eligible for special enrollment rights under HIPAA, you may enroll in any health plan option offered under the Omnibus Health Care Plan for which you are eligible or, if you're already enrolled in a health plan option, you may change health plan options if another option is available.

**Special Enrollment Due to Loss of Other Coverage**

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

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

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

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

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

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

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

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

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

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

**Special Enrollment Due to New Dependent Eligibility**
You and your eligible dependents can enroll in the plan (subject to certain conditions) if you acquire a dependent through marriage or formation of a new domestic partnership, birth, adoption or placement for adoption. You and your dependents must request special enrollment in writing no later than 31 days from the date of marriage, the date all of the requirements set forth in the *Chevron Affidavit of Domestic Partnership (F-6)* form are first met, birth, adoption or placement for adoption. The conditions that apply are as follows:

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

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

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

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

- **Effective date of coverage:**

  - **Upon marriage:** On the first day of the month coinciding with or following the date of marriage.
  - **Upon formation of a domestic partnership:** On the first day of the month coinciding with or following the date all of the requirements of the *Chevron Affidavit of Domestic Partnership (F-6)* form are first met.
  - **Upon birth:** On the date of the dependent's birth.
  - **Upon adoption or placement for adoption:** On the date of such adoption or placement for adoption.
  - **When adding a child (other than your own newborn or adopted child) to your coverage:** On the first day of the month coinciding with or following the date the child first becomes your dependent.

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

| Plan | Participation Begins: |
|---|---|
| **Medical PPO**<br>**Employee Coverage**<br>Includes prescription drug coverage. You're also automatically enrolled in the Chevron Vision Program for basic vision coverage. | • On your hire date, if you enroll in a medical plan within 31 days of your hire date.<br>• On the day you first become eligible, if you enroll in a medical plan within 31 days of the date you first become eligible.<br>• 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.<br>• 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.<br>• On the first day of the month coinciding with or following the date all of the requirements listed on the Chevron *Affidavit of Domestic Partnership* are first met, if you enroll within 31 days of first meeting the requirements listed on the Chevron Affidavit of Domestic Partnership.<br>• The following January 1, if you enroll in a medical plan during the open enrollment period. |
| **Medical PPO**<br>**Dependent Coverage**<br>Includes prescription drug coverage. You're also automatically enrolled in the Chevron Vision Program for basic vision coverage. | • On the same day your coverage begins, if you enroll yourself and your dependents at the same time.<br>• On the date of birth, if you enroll a newborn child within 31 days of the date he or she is born.<br>• 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.<br>• On the first day of the month coinciding with or following the date he or she becomes eligible, if you enroll a new spouse/domestic partner, child or stepchild (other than a newborn or newly adopted child) within 31 days.<br>• The following January 1, if you enroll in a medical plan during the open enrollment period. |
| **Before-Tax Contribution Plan** | • Generally at the same time as your participation in any one of the health plans.<br>• The following January 1, if you enroll in the plan during the open enrollment period. |

## When Participation Ends

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

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

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

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

### A Snapshot of When Coverage Ends

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

| Plan | Participation Ends When: |
|---|---|
| **Medical PPO**<br>Includes prescription drug coverage. You're also automatically enrolled in the Chevron Vision Program for basic vision coverage. | • You or your dependent is no longer eligible. Coverage ends on the last day of the month.<br>• You cancel coverage or stop making required contributions. Coverage for you and your dependents ends on the last day of the month for which contributions were received.<br>• You move out of the service area of your current medical plan and you must change to a plan offered where you live. New coverage takes effect on the first day of the following month.<br><br>Coverage for you and your dependents also ends after 31 days of the following types of leave:<br>• Personal Leave Without Pay.<br>• Leave for educational reasons.<br>• Long Union Business Leave (unless you elect to pay 100% of the cost of continued coverage).<br>If you or a dependent is hospitalized at the time coverage under the Medical PPO ends, benefits for charges incurred in the hospital can be paid until you or your dependent leaves the hospital. |

| Plan | Participation Ends When: |
|---|---|
| **Before-Tax Contribution Plan** | • As a result of a qualifying life event, you stop participating in all of the health plans to which Chevron requires you to contribute.<br>• You elect to make contributions on an after-tax basis (participation ends on the following December 31).<br>• You transfer to a company that doesn't participate in the **Medical PPO**.<br>• You no longer receive a paycheck from Chevron and, as a result, you're unable to make before-tax contributions.<br>• You're no longer eligible to participate because of a plan change, a change in your employment status or other reasons.<br>• The plan is terminated or your employer stops participating in the plan. |

**What Happens if You Die**
See the **If You Die** chapter of this summary plan description for information.

# how much you pay for coverage

You and Chevron currently share the cost of your medical plan, which includes automatic enrollment in the Prescription Drug Program for prescription drug coverage and the Chevron Vision Program for basic vision coverage.

Your cost for coverage depends on the medical plan you select and the number of dependents you cover. The cost of coverage is communicated each year during open enrollment. For detailed information about Chevron's contribution policy, see the Company Contributions for Medical Coverage section. For the most up-to-date costs for each plan, you can visit the Benefits Connection website at **hr2.chevron.com** or contact the HR Service Center.

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

Chevron Corporation, in its sole discretion, determines the amount that plan members contribute for coverage. In doing this, Chevron Corporation takes into account several factors, including the amount it has agreed to pay toward coverage and the expected cost of claims and expenses. In addition to the forgoing Chevron Corporation, in its sole discretion, may impose a tobacco surcharge, based on whether the plan member is a tobacco user, a non-tobacco user, or declines to disclose their tobacco use status. If a member fails to certify their tobacco use status in accordance with the established procedures, then such member will be deemed to be a tobacco user and will be subject to the tobacco surcharge. If the payment of claims and expenses exceeds contributions from plan members and Chevron, Chevron Corporation will make up the difference. However, this deficit would then be considered when Chevron Corporation determines future contribution rates for plan members.

# wellness programs

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

# health support

## 24/7 Nurseline

Anthem offers the 24/7 Nurseline℠ to Medical PPO members. Experienced, registered nurses are available any time, day or night – 24 hours a day, seven days a week – to answer your health questions and concerns. 24/7 NurseLine gives you another way to access health information. To use this service, call the number on the back of your ID card.

**Note:** If you have a medical emergency, call 911 instead of calling 24/7 NurseLine.

## Integrated Health Management (IHM) Team

A team of registered nurses with Anthem is available as part of your plan benefit. The Primary Nurse Team is dedicated solely to Chevron.

You can call the Primary Nurse Team with questions or concerns for health matters big and small. A primary nurse can help you with condition management (for example, diabetes or asthma), understanding an illness, an upcoming hospitalization, major surgery or treatment options.

In some situations, you might receive a call from a primary nurse directly. Your primary nurse will be alerted to your condition based on your medical and prescription drug claims. Your primary nurse is there to help answer your questions and support you in managing your condition. You may even receive educational materials and individualized support for your condition.

The Primary Nurse Team can also help you understand and follow your physician's treatment plan and self-care suggestions, provide you with educational materials and individualized support, find physicians or other health care professionals in the network as well as connect you with community resources.

The Primary Nurse Team currently provides support in the following areas:

- Case Management
- Treatment Decision Support
- Maternity Support Program
- Transplant Resource Services
- Cancer Support Program
- Kidney Resource Program
- Healthy Back Program
- Congestive Heart Failure
- Asthma
- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disorder (COPD)
- Diabetes

# medical coverage
## chevron medical PPO

Anthem Blue Cross (Anthem) is the claims administrator of medical benefits under the Medical PPO. You and your eligible dependents have this medical coverage if you are enrolled in the Medical PPO. This section describes the medical benefits under the Medical PPO.

# medical deductibles

There are different deductible amounts for covered medical services depending on if you see a network or an out-of-network provider. Amounts paid for covered medical services provided by a network provider also count toward the out-of-network annual deductible. Amounts paid for covered medical services provided by an out-of-network provider also count toward the network annual deductible.

| Medical Deductible Amount | Network | Out-of-Network |
|---|---|---|
| You Only | $1,000 | $2,000 |
| You + One Adult | $2,000 | $4,000 |
| You + Child(ren) | $2,000 | $4,000 |
| You + Family | $3,000 | $6,000 |

Each covered individual has a maximum network deductible equal to the *You Only* network deductible amount. For the *You and One Adult*, *You and Child(ren)* and *You and Family* coverage category levels, there is an overall maximum network deductible amount for all covered participants that corresponds to the coverage category elected. No more than the You Only network deductible amount can be applied toward the family network deductible for any one person to satisfy the You and Adult, You and Child(ren) or You and Family network deductible.

For example, if you choose the You and Family coverage tier, your annual network deductible is satisfied when the family's accumulation of network deductibles reaches $3,000, with no more than $1,000 applied for each family member. Your family could meet the $3,000 network deductible with charges of $1,000 for one member, $1,000 for a second member, $500 for a third member and $500 for a fourth member.

Each covered individual has a maximum out-of-network deductible equal to the *You Only* deductible amount. Once the covered individual reaches the *You Only* maximum out-of-network deductible amount, then coinsurance will apply to the covered individual, meaning the plan pays its share of covered charges. For the *You + One Adult*, *You + Child(ren)* and *You + Family* coverage category levels, there is an overall maximum out-of-network deductible amount for all covered participants that corresponds to the coverage category elected. No more than the *You Only* out-of-network deductible amount can be applied toward the family out-of-network deductible for any one person to satisfy the *You + One Adult*, *You + Child(ren)* or *You + Family* out-of-network deductible.

The following expenses don't count toward your network deductible:

- Co-payments
- Charges in excess of contracted rates for services provided by a network provider
- Charges in excess of the maximum allowable amount for services provided by an out-of-networ provider.
- Charges for services or supplies that aren't medically necessary.
- Charges for health care services and supplies that aren't covered under the plan.

- The Prescription Drug Program deductible (prescription drugs are subject to a separate deductible).
- Your share of the cost of medication purchased under the plan's Prescription Drug Program (prescription drugs are subject to a separate deductible).
- Additional expenses you pay because you don't follow the plan's Clinical Review procedures.
- Additional expenses you pay above certain benefit limits, such as expenses for durable medical equipment.
- Your share of the cost for services and supplies under the Mental Health and Substance Abuse Plan.

# medical out-of-pocket maximum feature

The Medical PPO has separate out-of-pocket maximums, one for prescription drug costs and the other for medical, mental health and substance abuse services, combined.

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 Medical PPO deductible, eligible out-of-pocket Medical PPO expenses and your eligible out-of-pocket expenses under the Mental Health and Substance Abuse Plan will all be applied to *one* annual out-of-pocket maximum amount as listed in the chart below.

While covered mental health and substance abuse services will apply to the combined out-of-pocket maximum, know that, depending on your usage, you may actually reach the MHSA Plan's out-of-pocket maximum for covered mental health and substance abuse services before you reach the Medical PPO Plan's combined annual out-of-pocket maximum amount. See the MHSA summary plan description for more information about the MHSA out-of-pocket maximum amount.

There are different out-of-pocket maximums for medical, mental health and substance abuse services combined, depending on if you see a network provider or an out-of-network provider. Amounts paid for covered services provided by a network provider also count toward the out-of-network maximum. Amounts paid for covered services provided by an out-of-network provider also count toward the network maximum.

After you pay your deductible, the plan pays a percentage of covered charges for the care you need, and you pay any costs above the amount paid by the plan.

| **Annual Out-of-Pocket Amount**<br>*Combined for medical, prescription drugs, mental health and substance abuse.* | **Network** | **Out-of-Network** |
|---|---|---|
| You Only | $5,000 | $10,000 |
| You + One Adult | $10,000 | $20,000 |
| You + Child(ren) | $10,000 | $20,000 |
| You + Family | $10,000 | $20,000 |

Each covered individual has a maximum network out-of-pocket amount equal to the You Only out-of-pocket maximum amount. For the You and One Adult, You and Child(ren) and You and Family coverage category levels, there is an overall maximum network out-of-pocket amount for all covered participants that corresponds to the coverage category elected. No more than the You Only amount can be applied for any one person to satisfy the You and Child(ren) or You and Family network out-of-pocket maximum.

For example, if you choose the You and Family coverage tier, your annual network out-of-pocket maximum is met when the family's accumulation of network out-of-pocket costs reaches $10,000, with no more than $5,000 applied for each family member. Your family could meet the $10,000 network maximum limit with charges of $5,000 for one member, $2,500 for a second member and $2,500 for a third member.

The following expenses *do not* count toward the medical and mental health services 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 contracted rates for services provided by network providers
- Charges in excess of the maximum allowable amount for services provided by out-of-network providers.
- Charges for services or supplies that aren't medically necessary.
- Charges for services or supplies that aren't covered under the Medical PPO plan.
- The Prescription Drug Program deductible.
- Your share of the cost of medication purchased through the plan's Prescription Drug Program.
- Additional expenses you pay because you don't follow the plan's Clinical Review procedures.
- Additional expenses you pay above certain benefit limits, such as expenses for durable medical equipment.
- Your share of the cost for services and supplies under the Mental Health and Substance Abuse Plan.

# how the plan works

When you need health care, you can go to a PPO network provider or to a provider who isn't in the network. The choice is yours. To get a list of network providers near you call Anthem or visit the website at **www.anthem.com/ca**.

## Networks

It's your responsibility to ensure that you use network providers if you want to receive the network reimbursement amount.

**If You Go to a PPO Network Provider**

Generally, the plan pays higher benefits for most kinds of care when you go to a PPO network provider. Network providers usually charge discounted rates for covered services they provide to plan members, and plan benefits are based on these discounted rates.

Generally, you don't have to file a claim form when you go to a PPO network provider. Your provider files the claim for you. Anthem sends you an Explanation of Benefits (EOB) statement that shows how much you owe for the care you received. Your provider bills you for that amount, unless you pay your portion of the charge when you receive the service.

**If You Go to an Out-of-Network Provider**

Generally, the plan pays lower benefits for most kinds of care when you go to an out-of-network provider, and plan benefits are subject to the maximum allowable amount. If you go to an out-of-network provider, you generally will first pay for the services and supplies you receive. You must then file a claim for benefits, and you then are reimbursed according to the plan's out-of-network benefit provisions. You are responsible for any charges above the maximum allowable amount. Benefits under the Medical PPO cannot be assigned, transferred or in any way made over to another party by you or your eligible dependent.

Anthem administers claims and provides Clinical Review services for the plan. You or your physician may need to contact Anthem's Clinical Review Program to qualify for full plan benefits for certain kinds of care.

## Pre-Service Review

Anthem may need to review proposed hospitalization and other specified procedures to confirm that they're medically necessary and appropriate for the condition being treated. Please refer to the Clinical Review section to determine which services require prior approval. Notification, or in some cases approval by Anthem, is required before full plan benefits can be paid for some kinds of care.

## Claims Administrator

Medical benefits claims under the Medical PPO are administered by a claims administrator –Anthem– in all states except Hawaii where the Medical PPO is not offered to employees.

Anthem reviews, approves (or denies) and processes all claims other than those for outpatient prescription drugs, basic vision care and mental health and substance abuse. Anthem also manages the PPO network of providers. In addition, Anthem staff informs plan members which charges are covered and which aren't covered under the plan.

- For a list of Anthem PPO network providers, you can log on to the website at **www.anthem.com/ca** or call Anthem. You can reach Anthem (for Clinical Review) between 8 a.m. and 8 p.m. Pacific time, Monday through Friday.

# what the plan pays

This section provides information about the network and out-of-network benefits for covered services. To receive the full benefits for some kinds of care, you have to follow Clinical Review procedures for the Medical PPO. The plan also includes a Prescription Drug Program. For more information, see Clinical Review and Prescription Drug Program in this section.

### Acupuncture

**Network** 100% of contracted rates after a $40 copayment, no deductible, for office visits up to a maximum of 20 visits per calendar year (combined network and out-of-network visits).

**Out-of-Network** 60% of the maximum allowable amount after deductible for office visits up to a maximum of 20 visits per calendar year (combined network and out-of-network visits).

The plan pays for acupuncture services provided by a licensed or certified physician, chiropractor, or acupuncturist, acting within the scope of that license or certification, to treat chronic pain, or nausea that is related to surgery, pregnancy or chemotherapy, up to a maximum of 20 visits (combined network and out-of-network visits) per calendar year.

### Allergy Treatment

**Network** 100% of contracted rates after a $40 copayment, no deductible, for office visits; 80% of contracted rates after deductible for treatment in an outpatient facility. .

**Out-of-Network** 60% of the maximum allowable amount after deductible.

The plan helps pay for allergy testing and treatment, including the injection and cost of allergy serum. If you receive allergy treatment (for example, allergy injections) at a provider's office without a physician's office visit charge, the plan pays 100 percent of the contracted rate if network and 60 percent of the maximum allowable amount if out-of-network with no copayment and no deductible.

### Ambulance Transportation

**Emergency** **Network:** 80% of contracted rates after deductible.

**Out-of-network:** 80% of billed charges after deductible.

**Nonemergency** **Network:** 80% of contracted rates after deductible.

**Out-of-network:** 60% of the maximum allowable amount after deductible.

The plan pays for emergency ambulance (land or air) transportation by a licensed ambulance service to the nearest hospital where emergency health services can be performed. Also covered, with authorization, is nonemergency, but medically necessary, transportation by ambulance, regularly scheduled airline, railroad or air ambulance to the nearest medical facility qualified to give the required treatment.

## Birth and Newborn Charges

| | |
|---|---|
| **Network** | 100% of contracted rates, no deductible, for physician services considered preventive; 80% of contracted rates after deductible for physician services that are not considered preventive and facility charges. |
| **Out-of-Network** | 60% of the maximum allowable amount, no deductible, for physician services considered preventive; 60% of the maximum allowable amount after deductible for facility charges. |

The plan covers delivery and subsequent physician charges for a healthy newborn including breastfeeding support, supplies and counseling. Covered charges include:

- Hospital room and board for you and your baby (the healthy baby is not subject to his or her own deductible while initially in the hospital after delivery).
- Inpatient care for you.
- Inpatient well-baby care (including routine nursing care, pediatrician services and miscellaneous tests).
- Services provided by physicians and nurses during delivery.
- Hospital services and supplies.
- Licensed birthing center (limited to $1,000 per pregnancy).
- A circumcision performed within 28 days of the birth, whether performed in or out of the hospital.

You don't have to get advance approval from Anthem to have your baby in a hospital. However, you'll need to notify Anthem to make sure you qualify for the full plan benefits if your physician thinks you'll have to stay in the hospital:

- More than 48 hours after a normal delivery.
- More than 96 hours after a cesarean delivery.

The following applies for both network and out-of-network childbirth services. No approval or preauthorization is needed from Anthem for maternity admissions. 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).

## Birthing Centers

**Network** 80% of contracted rates, to a maximum of $1,000 per pregnancy.

**Out-of-Network** 60% of the maximum allowable amount, to a maximum of $1,000 per pregnancy.

The plan covers maternity- and pregnancy-related services provided at an approved birthing center, such as room and board and miscellaneous supplies and services, including anesthetics and their administration.

A birthing center is a facility that operates under the license of a hospital and provides a home-like setting under a controlled environment for the purpose of childbirth.

If you choose a midwife or nurse-midwife who is supervised by a network physician, these services are covered at 80 percent of contracted rates after the deductible. If the midwife is supervised by an out-of-network physician, these services are covered at 60 percent of the maximum allowable amount after the deductible.

Home delivery is not covered under the plan.

## Chemotherapy Treatment

**Network** 80% of contracted rates after deductible.

**Out-of-Network** 60% of the maximum allowable amount after deductible.

Providers can contact Anthem to participate in the Cancer Care Quality Program by calling 1-844-627-1632. The program is of no cost to the member or the provider.

## Chiropractic Care

**Network** 100% of contracted rates after a $40 copayment, no deductible for office visits s; 80% of contracted rates, no deductible, for treatment in an outpatient facility; up to a maximum of 20 visits per calendar year (combined network and out-of-network visits).

**Out-of-Network** 60% of the maximum allowable amount after deductible for office visits or treatment in an outpatient facility; up to a maximum of 20 visits per calendar year (combined network and out-of-network visits).

The plan covers the services of a physician or chiropractor for the detection or correction (manipulation), by manual or mechanical means, of structural imbalance or distortion in the spine.

The plan pays benefits only for therapy services given by a licensed or certified provider acting within the scope of that license or certification.

## Clinical Trials
## Office Visits*

**Network** 100% of contracted rates after a $40 copayment per visit, no deductible.

**Out-of-Network** 60% of the maximum allowable amount after deductible.

## Clinical Trials
## Hospital Care* (inpatient and outpatient)

**Network** 80% of contracted rates after deductible.

**Out-of-Network** 60% of the maximum allowable amount after deductible.

*Review the **Hospital Care and Office Visit** tables in this section for additional coverage information.

As required by the Patient Protection and Affordable Care Act, the plan provides coverage for *certain routine patient care costs incurred during participation* in an approved clinical trial for:

- Cancer or other life-threatening diseases or conditions.
- Cardiovascular disease (cardiac/stroke) which is not life threatening for which the claims administrator determines a clinical trial meets the plan's qualifying clinical trial criteria.
- Surgical musculoskeletal disorders of the spine, hip and knees which are not life threatening for which the claims administrator determines a clinical trial meets the plan's qualifying clinical trial criteria.
- Other diseases or disorders which are not life threatening for which the claims administrator determines a clinical trial meets the plan's qualifying clinical trial criteria.

For more information about what services are considered routine patient care costs and what qualifies as an approved clinical trial, contact Anthem.

## Cochlear Implants

**Network** 80% of contracted rates after deductible.

**Out-of-Network** 60% of the maximum allowable amount after deductible.

The plan pays covered charges for services and supplies, including implantable components, for bilateral or unilateral cochlear implantation where required due to profound prelingual, perilingual or postlingual bilateral sensorineural hearing loss in children and when due to profound postlingual bilateral sensorineural hearing loss in adults (This includes adults who were initially diagnosed with prelingual or perilingual bilateral sensorineural hearing loss and who have progressed to severe to profound postlingual bilateral sensorineural hearing loss). Cochlear implantation not described above, including unilateral or bilateral cochlear implants in adults when due to prelingual or perilingual sensorineural hearing loss, and cochlear hybrid implants, are not covered.

The external components for covered implantation (such as a speech processor, microphone, and transmitter coil) are considered durable medical equipment (DME) – see the Durable Medical Equipment chart.

The plan will pay only for a single purchase (including repair or replacement) for cochlear implants once every three years.

## Colonoscopy

**Network** 100% of contracted rates for preventive colonoscopies; 80% of contracted rates after deductible for routine colonoscopies.

**Out-of-Network** 60% of the maximum allowable amount for preventive colonoscopies; 60% of the maximum allowable amount after deductible for routine colonoscopies.

The plan covers colonoscopies prescribed by your physician, including those performed as a preventive screening, and including charges incurred for general anesthesia for such colonoscopies.

## Dental Care

**Network** 80% of contracted rates after deductible.

**Out-of-Network** 60% of the maximum allowable amount after deductible.

The plan helps pay for the following kinds of dental care and oral surgery only:

- Dentists' charges for the repair or initial replacement of sound, natural teeth that are damaged or lost as a result of an accident other than a chewing injury. Initial contact with the dentist or physician must occur within 72 hours and services must begin within three months and be completed within 12 months of the date of the accident. (You must notify Anthem before receiving services in a hospital.).
- Oral surgery to correct fractures and dislocations resulting from an accident. Services must begin within three months and be completed within 12 months of the date of the accident. (You must notify Anthem before receiving services in a hospital.).
- Oral surgery for tumors and cysts of the mouth, except for those caused by diseases of the teeth or gums.
- Oral surgery to control a medical condition other than TMJ, such as osteomyelitis, cleft palate, burns and orthognathic surgery, which are within the mouth but not tooth- or gum-related.
- Facility and anesthesia charges for any of the covered procedures or when necessary due to an underlying medical condition.

## Surgical TMJ Treatments

The plan helps pay for oral surgery for treatment of temporomandibular joint dysfunction (TMJ).

**Network** 80% of contracted rates after deductible.

**Out-of-Network** 60% of the maximum allowable amount after deductible.

### Non-Surgical TMJ Treatments

The plan pays covered charges for certain kinds of nonsurgical TMJ treatments. This includes orthotic splints and certain other kinds of TMJ treatments, but not procedures, restorations or prostheses that permanently alter the bite.

| | |
|---|---|
| **Network** | 80% of contracted rates after deductible. |
| **Out-of-Network** | 60% of the maximum allowable amount after deductible. |

### Emergency Services (within the U.S.)

| | |
|---|---|
| **Network** | 100% of contracted rates after a $250 copayment per emergency room visit, no deductible. |
| **Out-of-Network** | 100% of billed charges after a $250 copayment per emergency room visit, no deductible. |

The plan pays covered charges for emergency room care, radiology, anesthesia and pathology services.

To make sure you qualify for full benefits, you or your physician must notify Anthem within two business days after an emergency hospital admission. If you don't follow the Clinical Review procedures, the percentage of benefits paid for covered charges for your emergency care may be reduced to 60 percent in network or 60 percent out-of-network, after you satisfy your deductible.

## Family Planning and Infertility Services

**Network** 80% of contracted rates after deductible.

**Out-of-Network** 60% of the maximum allowable amount after deductible.

The plan helps pay covered charges for family planning and related services. These services include:

- The diagnosis and treatment of medical conditions that result in infertility, including expenses related to surgery and drug therapy.
- Artificial insemination.
- Vasectomy.
- Tubal ligation.
- Reversal of vasectomy or tubal ligation.
- Sperm preparation.
- Selection reduction in multiple births
- Abortions, either medically necessary or elective.

In addition, the following services to facilitate a pregnancy are covered by the plan and are subject to an aggregate $5,000 lifetime maximum benefit:

- In vitro fertilization.
- Embryo transfer.
- Gamete intrafallopian transfer.
- Zygote intrafallopian transfer.
- Tubal ovum transfer.

Charges related to surrogate parents and charges incurred by a sperm or egg donor are not covered.

Included are physician-prescribed contraceptives that require insertion by a physician or significant physician follow-up, such as injectable contraceptives, morning-after pills, implants (such as Depo-Provera or Levonorgestrel), IUDs, diaphragms, other removable devices and related office visits. Oral contraceptives are covered under the Prescription Drug Program. Over-the-counter supplies are not covered.

**Gender Identity Disorder**
**Hospital Care* (inpatient and outpatient)**

| | |
|---|---|
| **Network** | 80% of contracted rates after deductible. |
| **Out-of-Network** | 60% of the maximum allowable amount after deductible. |

**Gender Identity Disorder**
**Office Visits***

| | |
|---|---|
| **Network** | 100% of contracted rates after a $40 copayment per visit, no deductible |
| **Out-of-Network** | 60% of the maximum allowable amount after deductible. |

*Review the **Hospital Care and Office Visit** tables in this section for additional coverage information.

**Before beginning treatment, you or your physician must notify Anthem** to request a Clinical Review at least two business days before you're admitted to the hospital for network or out-of-network hospitalization. If you don't follow the Clinical Review procedures, the percentage of benefits paid for covered charges will be reduced to 60 percent in network and 60 percent out of network, after you satisfy the deductible.

The plan pays benefits for inpatient and outpatient treatment of Gender Identity Disorder/Dysphoria as follows:

- Continuous hormone replacement - hormones of the desired gender injected by a medical provider. Note. Coverage may be available for oral and self-injected hormones may be covered under the Chevron Corporation Prescription Drug Program, Supplement F to the Omnibus Plan.
- Genital surgery and surgery to change specified secondary sex characteristics.
    - The treatment plan must conform with identifiable external sources and/or evidence-based professional society guidance, as well as Anthem's clinical guidelines; and
    - For irreversible surgical interventions, the patient must be age 18 years or older; and
    - Prior to surgery, the patient must complete 12 months of successful continuous full time real life experience in the desired gender.
- Laboratory testing to monitor the safety of continuous hormone therapy.
- The surgery must be performed by a qualified physician at a facility with a history of treating individuals with gender identity disorder, as determined by Anthem.

## Gender Identity Disorder

*continued*

Anthem has specific guidelines regarding benefits for treatment of gender identity disorder. Contact Anthem at the telephone number on your ID card for information about these guidelines.

**Important:** Certain patients will be required to complete continuous hormone therapy prior to surgery. In consultation with your physician, this will be determined by Anthem on a case-by-case basis through the precertification process.

**The following services are not covered under the plan:**

- Abdominoplasty.
- Blepharoplasty
- Breast augmentation
- Brow lift
- Calf implants
- Cryopreservation of fertilized embryos
- Drugs for hair loss or growth
- Drugs for sexual performance or cosmetic purposes (except for hormone therapy described above)
- Electrolysis
- Face lift
- Facial bone reconstruction
- Facial implants
- Gluteal augmentation
- Hair removal/hairplasty, when the criteria above have not been met
- Jaw reduction (jaw contouring)
- Lip reduction/enhancement
- Lipofilling/collagen injections
- Liposuction
- Nose implants
- Pectoral implants
- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics
- Rhinoplasty
- Sperm preservation in advance of hormone treatment or gender surgery
- Thyroid cartilage reduction (chondroplasty);
- Voice modification surgery.
- Voice therapy.
- Transportation, meals, lodging or similar expenses.
- Treatment of the negative effects from hormone therapy that are not otherwise covered charges.
- Treatment received outside of the United States.

In addition, the following family planning services, when otherwise covered under the plan, are covered with respect to an individual who has had a gender reassignment only when typically provided to the individual's current gender and not those typically provided to the individual's former gender: in vitro fertilization, embryo transfer, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and tubal ovum transfer.

## Hearing Aids

**Network** 80% of contracted rates after deductible.

**Out-of-Network** 80% of the maximum allowable amount after deductible.

The plan pays covered charges for hearing aids for dependent children who are under age 26, including bone anchored (BAHA) hearing aids when medically necessary, Hearing aids are covered up to maximum of $5,000 once every 4 years. Coverage for cochlear implants is described in the Cochlear Implant section above.

**Hearing Aids:** Coverage includes the hearing aid device and fitting. Batteries and routine maintenance of the device are not covered.

**Bone Anchored Hearing Aids (BAHA):** Coverage for BAHA includes the actual hearing device as well as the surgery to attach or remove the device (surgery is covered under Surgical section below). Coverage for BAHA is limited to the following conditions:

- Craniofacial anomalies where abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity exists that would not be adequately remedied by a wearable hearing aid.

## Home Health Care

**Network** 80% of contracted rates, no deductible, up to a maximum of 60 visits per calendar year (combined network and out-of-network visits).

**Out-of-Network** 60% of the maximum allowable amount, no deductible, up to a maximum of 60 visits per calendar year (combined network and out-of-network visits).

Any combination of network and out-of-network benefits is limited to 60 visits per calendar year. One visit equals four hours of skilled home health care services.

The plan pays covered charges for medical services provided in your home by a home health care agency. No benefits are payable for custodial care.

Services received from an approved home health care agency must be both of the following:

- Ordered by a physician.
- Provided by or supervised by a registered nurse in your home or by a home health aide supervised by a registered nurse.

Benefits are available only when the home health care agency services are provided on a part-time, intermittent schedule and when skilled home health care is required.

## Home Health Care
*continued*

Skilled home health care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- It is ordered by a physician.
- It is not delivered for the purpose of assisting with activities of daily living, including, but not limited to, dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not custodial care.

Anthem decides if skilled home health care is required by reviewing both the skilled nature of the service and the need for physician-directed medical management. A service is not determined to be skilled simply because there is not an available caregiver.

## Hospice Care

**Network** 80% of contracted rates, no deductible.

**Out-of-Network** 60% of the maximum allowable amount, no deductible.

These benefits are payable whether covered care is provided in an approved hospice facility or in the patient's home. To receive full plan benefits, you should notify Anthem before services begin.

Hospices offer an alternative to hospital care for the treatment of terminally ill patients. These programs also provide counseling for the families of the terminally ill.

To be eligible for the following hospice care benefits, the patient's physician must certify that the patient is terminally ill and has a life expectancy of six months or less. Hospice care must be ordered by a physician and must be delivered or supervised by licensed technical or professional medical personnel. Coverage includes:

- Inpatient room and board accommodations, services and supplies.
- Part-time nursing care by or under the supervision of a registered nurse.
- Part-time or intermittent nursing care provided at the patient's home by or under the supervision of a registered nurse furnished by an approved home health care agency.
- Part-time or intermittent home health aide services, consisting primarily of caring for the patient, that are provided by an approved home health care agency.

## Hospital Care (inpatient and outpatient)

**Network** 80% of contracted rates after deductible.

**Out-of-Network** 60% of the maximum allowable amount after deductible.

If you have preadmission testing (other than surgical testing), such as laboratory and X-ray work, performed at the same hospital before inpatient surgery, these tests are covered at 100 percent for contracted network and 60% for allowable out-of-network covered charges; no deductible applies to both. Surgical testing for inpatient or outpatient surgery is covered at 80 percent of contracted rates in-network or 60 percent of the maximum allowable amount out of network, both after the deductible.

The plan covers charges for the following hospital services and supplies:

- Private room and board charges up to the hospital's average semiprivate room rate (excludes charges for personal items such as newspapers, telephones, radios and TVs).
- Medical services and supplies provided while you're receiving inpatient or outpatient care at a hospital.
- Care provided in hospital rooms designed for specialized care, such as operating rooms, intensive care units and emergency rooms.
- Tests and therapies provided while you're an inpatient.

Charges for confinement in a non-acute-care section of an acute-care hospital, such as an outpatient surgery center or birthing center, will be covered at the level of coverage for that type of facility, not at the coverage level of the acute-care hospital.

To make sure you qualify for full hospitalization benefits, you or your physician must notify Anthem to request a Clinical Review at least two business days before you're admitted to the hospital for network or out-of-network hospitalization or within two business days after an emergency admission. If you don't follow the plan's Clinical Review procedures, the percentage of benefits paid for covered charges for your hospital care will be reduced to 60 percent in network and 60 percent out of network.

The following applies for both network and out-of-network childbirth services: No approval or preauthorization for maternity admissions is needed from Anthem. 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). Note that authorization must be obtained from Anthem for a length of stay in excess of these periods. For a description of benefits, see the Birth and Newborn Charges chart under What the Plan Pays in this section.

## Lab Tests and X-Rays

| | |
|---|---|
| **Network** (inpatient and outpatient) | 80% of contracted rates after deductible, regardless of where the service is performed. |
| **Out-of-Network** (inpatient and outpatient) | 60% of the maximum allowable amount after deductible, regardless of where the service is performed. |

Benefits are paid only when lab tests and X-rays are requested or prescribed by a physician. Network lab tests that are part of preventive prenatal care are covered at 100%.

## Medical Supplies and Equipment

| | |
|---|---|
| **Network** | 80% of contracted rates after deductible. |
| **Out-of-Network** | 60% of the maximum allowable amount after deductible. |

The plan helps pay covered charges for the purchase of needed medical supplies and equipment, including:

- Casts, splints, dressings, braces and crutches.
- Ostomy supplies.
- Intravenous (iv) infusion therapy supplies.
- Prosthetic devices, such as breast prostheses, artificial limbs and eyes to initially replace natural body parts, and their subsequent repair and replacement if they malfunction, limited to a single purchase of each type of prosthetic device once every three years.
- Initial pair of eyeglasses or contact lenses, including fitting, following surgery or accidental injury to the lens of an eye.
- Glucometers. (Note: covered charges for diabetic testing supplies are paid under the Prescription Drug Program.)
- Orthopedic shoes and needed modifications to the shoes, if shoes are part of a medically necessary brace.

**Medical Supplies and Equipment**
*continued*

The plan helps pay covered charges for the purchase of needed medical supplies and equipment, including:

- Durable medical equipment, including:
  - Equipment to assist mobility, such as a standard wheelchair.
  - A standard hospital-type bed.
  - Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and mask).
  - Delivery pumps for tube feeding (including tubing and connectors).
  - Braces that stabilize an injured body part (including necessary adjustments to shoes to accommodate braces), but dental braces are excluded from coverage.
  - Mechanical equipment necessary for the treatment of chronic or acute respiratory failure, but air conditioners, humidifiers, dehumidifiers, air purifiers, air filters and personal comfort items are excluded from coverage
  - External components (speech processor, microphone, and transmitter coil, for example) of covered cochlear implants.

If you rent durable medical equipment, plan benefits are based on rental charges up to the amount that would be paid to buy the equipment.

If you can prove that you have a long-term need for the equipment and that rental charges are expected to equal or exceed the purchase price of the equipment, Anthem may direct you to buy the equipment rather than rent it. You should notify Anthem prior to purchasing or renting durable medical equipment with a retail value or cumulative rental cost over $1,000. To receive benefits, the patient must purchase or rent the durable medical equipment from a network provider. The plan pays benefits only for a single purchase (including repair or replacement or both) of a type of durable medical equipment once every three years. The plan will pay only for the most cost-effective piece of equipment that would meet the patient's functional needs.

**Non-U.S. Medical Services**

The plan will reimburse you at the out-of-network percentage level of billed charges after you meet the deductible for medically necessary treatments and services incurred outside the U.S. Emergency services will be reimbursed at the network percentage level of billed charges after you meet the deductible. Notification or authorization is not required for services received outside the U.S. However, the plan will not reimburse you for services and supplies that do not meet the definition of a covered charge or if the services and supplies were obtained outside the U.S. because you were or would be denied coverage for such services and supplies within the U.S.

## Obesity Surgery

Generally, except where noted:

**Network** 80% of contracted rates after deductible.

**Out-of-Network** 60% of the maximum allowable amount after deductible.

Obesity surgery is covered only if there is a diagnosis of morbid obesity. Prior to the surgery you must notify Anthem.

## Office Visits

Generally, except where noted:

**Network** 100% of contracted rates after a $25 copayment if a primary care physician per visit, no deductible or after a $40 copayment if a specialist, no deductible.

**Out-of-Network** 60% of the maximum allowable amount after deductible.

The plan pays covered charges for most medical office visits (visits to your physician for diagnosis and treatment of sickness or injury or for a medical consultation).

The plan pays covered charges for office visits for preventive care as described in the Preventive Care chart under What the Plan Pays in this section. The plan also pays covered charges for surgical services or other invasive-type procedures performed in a physician's office, which are considered surgical by the American Medical Association (AMA) as described under Surgery in this section.

## Online Visits

Online visits are covered under the plan only from providers who contract with LiveHealth Online.

**Network** 100% of contracted rates after a $25 copayment if a primary care physician or $40 copayment if a specialist, per visit, no deductible.

**Out-of-Network** Out-of-network benefits are not applicable.

When available in your area, covered charges will include online visits from a LiveHealth Online Provider at **www.livehealthonline.com**. Covered services include medical consultations using the Internet via webcam, chat, or voice.

Non-covered services include, but are not limited to, the following:

- Reporting normal lab or other test results.
- Office visit appointment requests or changes.
- Billing, insurance coverage, or payment questions.
- Requests for referrals to other physicians or healthcare practitioners.
- Benefit precertification.
- Consultations between physicians.
- Consultations provided by telephone, electronic mail, or facsimile machines.

You will be financially responsible for all costs associated with non-covered services.

## Organ and Tissue Transplants

**Network** 80% of contracted rates after deductible.

**Out-of-Network** 60% of the maximum allowable amount after deductible.

Prior to the transplant you must notify Anthem. The transplant must be done at a facility approved or designated by Anthem. Supplies and services for the following organ or tissue transplants or multiple organ transplants are covered by the plan when ordered by a physician:

- Bone marrow transplants, either from you or from a compatible donor, and peripheral stem cell transplants, with or without high-dose chemotherapy (not all bone marrow transplants meet the definition of medically necessary).
- Heart transplants.
- Heart-lung transplants.
- Lung transplants.
- Kidney transplants.
- Kidney-pancreas transplants.
- Liver transplants.
- Liver-small bowel transplants.
- Pancreas transplants.
- Small bowel transplants.
- Cornea transplants provided by a physician at a hospital (cornea transplants need not be performed at an approved network transplant facility in order to receive network benefits).

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage. Charges for non-biologically-related donor searches for purposes of stem cell transplants are limited to $25,000 per transplant procedure. Charges for non-biologically-related donor searches for purposes of bone marrow transplants are limited to $25,000 per transplant procedure.

## Organ and Tissue Transplants
*continued*

Certain procedures are covered only if there is accepted clinical evidence that the procedure is an effective means to treat your specific medical condition. You must notify Anthem in advance. The plan does not cover any organ or tissue transplant if it is considered by generally recognized professionals or publications as experimental, investigative or unproven in the treatment of the specific medical condition.

**Transportation and Lodging**
Reimbursements of expenses for travel and lodging for the transplant recipient and a companion are available as follows:

- Plan reimbursements for transportation and lodging are available only if the patient is using an approved network transplant facility.
- The plan pays for transportation of the patient and one companion, who is traveling on the same day(s) to and from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- The plan pays reasonable and necessary expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 per day for all family members combined. If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered and lodging will be reimbursed up to the $100 per diem rate for all family members combined.
- Travel and lodging expense reimbursement is available only if the transplant recipient resides more than 50 miles from the approved network transplant facility.

There is a combined overall lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by the transplant recipient and companion(s) and reimbursed under the plan in connection with all transplant procedures.

Donor charges are covered only if the recipient of the organ/tissue transplant is covered under this plan.

Anthem will assist the patient and family with travel and lodging arrangements.

## Orthotics

**Network** 80% of contracted rates after deductible.

**Out-of-Network** 60% of the maximum allowable amount after deductible.

The plan can help pay covered charges for the following:

- Braces for treatment to an injured body part.
- Braces to treat curvature of the spine.
- Allowed items under Medical Supplies and Equipment as durable medical equipment.

All other orthotic appliances and devices such as foot orthotics or orthotic braces available over-the-counter are excluded from coverage.

## Podiatry Services

**Network** 100% of contracted rates after a $40 copayment, no deductible, for office visits; 80% of contracted rates, no deductible, for treatment in an outpatient facility.

**Out-of-Network** 60% of the maximum allowable amount after deductible for office visits or treatment in an outpatient facility.

The plan can help pay covered charges for podiatry services that are required as the result of a severe systemic disease. The plan does not cover routine foot care, including care for corns or calluses, nail trimming, cleaning and soaking the foot, and treatment of flat feet. For details, see Expenses That Aren't Covered Under the Plan in this section.

## Prenatal Care

**Network** 100% of contracted rates for routine prenatal care that qualifies as preventive care, no deductible.

80% of contracted rates, after deductible, for prenatal care that does not qualify as preventive care.

**Out-of-Network** 60% of the maximum allowable amount for routine prenatal care that qualifies as preventive care.

60% of the maximum allowable amount, after deductible, for prenatal care that does not qualify as preventive care.

Expectant mothers can participate in a special education program called the Future Moms Maternity Program managed by Anthem. To enroll in or learn more about this voluntary program, call Anthem to speak with a nurse. Future Moms is provided at no charge to you and gives you the following:

- Telephone access to registered nurses throughout your pregnancy.
- Telephone consultation by a registered nurse to ensure that your pregnancy is going well.
- A packet of valuable information related to pregnancy.

## Preventive Care

**Network** 100% of contracted rates, no deductible.

**Out-of-Network** 60% of the maximum allowable amount, no deductible.

Preventive care services as required by the Patient Protection and Affordable Care Act and in accordance with guidelines based on recommendations from nationally recognized organizations, such as the U.S. Preventive Services Task Force. For a list of preventive care services you can contact Anthem or go online at **www.anthem.com/preventive-care/**.

## Private-Duty Nursing

**Network** 80% of contracted rates after deductible, up to 1,000 hours or 120 days per calendar year (whichever comes first) (combined network and out-of-network).

**Out-of-Network** 60% of the maximum allowable amount after deductible, up to 1,000 hours or 120 days per calendar year (whichever comes first) (combined network and out-of-network).

If your physician prescribes private-duty nursing care outside the hospital, be sure to contact Anthem to receive full plan benefits. You must notify Anthem at least two business days before you or a dependent begins receiving private-duty nursing services; otherwise, the percentage of benefits paid for covered charges is reduced to 60 percent if in network or 60 percent for out of network.

The plan will not pay benefits for private-duty nursing in a hospital or skilled nursing facility because it is not considered medically necessary since hospitals provide adequate nursing services. Custodial care isn't covered by the plan, even if it's prescribed by a physician and provided by a nurse.

## Rehabilitation Therapy (inpatient)

**Network** 80% of contracted rates after deductible, up to a maximum of 120 visits per calendar year (combined network and out-of-network visits).

**Out-of-Network** 60% of the maximum allowable amount after deductible, up to a maximum of 120 visits per calendar year (combined network and out-of-network visits).

Benefits are available for services and supplies received during an inpatient stay in an inpatient rehabilitation facility, including room and board in a semiprivate room (a room with two or more beds).

In general, the intent is to provide benefits for members who are convalescing from an injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services that are less than those available in a general acute hospital but greater than those available in the home setting. The patient is expected to improve to a predictable level of recovery.

Benefits are available when rehabilitation services are needed on a daily basis and, accordingly, benefits are not available when these services are required intermittently (such as physical therapy three times a week). However, coverage for therapies on intermittent frequencies may be covered under other plan benefits.

Benefits are not available for custodial, domiciliary or maintenance care (including administration of enteral feeds). This care is not covered, even if it is ordered by a physician, if it is for the primary purpose of meeting personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Remember to notify Anthem at least two business days before therapy begins.

## Rehabilitation Therapy (outpatient)

**Network** 80% of contracted rates after deductible, up to a maximum of 30 visits per calendar year (combined network and out-of-network visits).

**Out-of-Network** 60% of the maximum allowable amount after deductible, up to a maximum of 30 visits per calendar year (combined network and out-of-network visits).

The plan pays benefits for short-term outpatient rehabilitation services for pulmonary rehabilitation therapy and cardiac rehabilitation therapy. With any combination of network and out-of-network benefits, outpatient rehabilitation therapy is limited to 30 visits of pulmonary rehabilitation therapy per calendar year and 30 visits of cardiac rehabilitation therapy per calendar year. These limits, however, will not be combined with other therapy limits. The rehabilitation services must be performed by a licensed therapy provider under the direction of a physician.

## Second and Third Physician Opinions

**Network** 80% of contracted rates after deductible.

**Out-of-Network** 60% of the maximum allowable amount after deductible

The second or third opinion must be obtained from a board-certified surgeon who is not the surgeon originally scheduled to perform the surgery. The plan can help pay covered charges for the following:

- Charges for laboratory and x-ray examinations.
- Charges for the diagnostic procedures associated with the consultation.

See the surgery section below for second opinion requirements for certain surgeries.

## Skilled Nursing Facility Care

**Network** 80% of contracted rates after deductible, up to 120 calendar days (combined network and out-of-network).

**Out-of-Network** 60% of the maximum allowable amount after deductible, up to 120 calendar days (combined network and out-of-network).

## Skilled Nursing Facility Care

*continued*

After you pay the deductible, the plan pays a percentage of covered charges for care in an approved skilled nursing facility for up to 120 days each calendar year (combined network and out-of-network).

If a physician prescribes the care in a skilled nursing facility and you or your enrolled dependent would otherwise be cared for in a hospital (and the care is not custodial), the plan pays covered charges for the following services and supplies:

- Semiprivate room and board.
- Skilled nursing care.
- Medical supplies and equipment.
- Prescribed drugs and biologicals.
- Other services ordinarily provided by the facility.

The confinement must be the result of the same or a related condition as the hospital confinement and must be supervised and certified in writing by a physician.

You or your physician should call Anthem to make sure the facility you select qualifies as a skilled nursing facility under the terms of the plan. The plan doesn't pay any benefits for custodial care, even if it's provided by an approved skilled nursing facility. If your stay in the facility extends into the next calendar year, an additional 120 days of benefits are available without a second hospital confinement.

You should notify Anthem at least two business days before receiving services.

## Surgery

This section describes the benefits available under this plan for:

- Surgery
- Musculoskeletal surgeries (hip, knee, back and spine)
- Multiple Surgical Procedures
- Reconstructive Surgery
- Second and Third Surgical Opinions

**Surgery**

Generally, except where noted:

**Network** 80% of contracted rates after deductible.

**Out-of-Network** 60% of the maximum allowable amount after deductible.

- If you need to be hospitalized for an operation, you or your physician must notify Anthem in order to receive the full benefits provided by the plan. If it is not an emergency, you should call at least two business days before surgery is performed. If it is an emergency, you should call within two business days after emergency surgery is performed.
- If you have any preadmission testing (other than surgical testing), such as laboratory and X-ray work, performed before a hospital admission for scheduled inpatient surgery, the testing is covered at either 100 percent of contracted rates (network) or 60 percent of the maximum allowable amount (out-of-network) with no deductible. The tests must be performed in the same hospital in which the surgery will be performed.
- Pre-surgical testing for inpatient or outpatient surgery is covered at the 80 percent of contracted rates (network) or 60 percent of the maximum allowable amount (out-of-network), after the deductible.

The Medical PPO can help pay covered charges for:

- Surgeons' services (including charges for any medically necessary assistant surgeon or standby surgeon).
- Anesthesia supplies and the services of an anesthesiologist.
- Hospital operating and recovery rooms; services and supplies associated with the surgery.
- Ambulatory surgical center operating and recovery rooms; services and supplies associated with the surgery.
- Outpatient surgical procedures.
- Certain organ and tissue transplants, when ordered by a physician.
- Certain reconstructive surgery.
- Second and third surgical opinions.

See the **Surgery - Musculoskeletal surgeries (hip, knee, back and spine)** table in this section for additional second opinion requirements.

**Surgery**
**Musculoskeletal surgeries (hip, knee, back and spine)**
For employees enrolled in the plan who are scheduled for a knee, hip, back or spine surgery greater than seven days out, they are required to contact 2nd MD for a second opinion. If a second opinion is not obtained from 2nd MD prior to one of these surgeries, the employee will be responsible for an additional $400 of out-of-pocket costs, whether or not the annual deductible has been met. The employee is only responsible for obtaining the second opinion. If your physician recommends the surgery be scheduled in seven days or less, it will be considered an emergency surgery and not subject to the requirement to obtain a second opinion through 2nd MD. This requirement is for employees only. For information on 2nd MD program eligibility please review the **Wellness** summary plan description, **Health Decision Support** chapter available on **hr2.chevron.com**.

**Surgery**
**Multiple Surgical Procedures**

| | |
|---|---|
| **Network** | 80% of contracted rates after deductible. |
| **Out-of-Network** | 60% of the maximum allowable amount for the primary surgical procedure, after deductible; plus<br><br>60% of the maximum allowable amount for each additional surgical procedure, after deductible. |

However, if more than one procedure is performed by a non-network provider through the same incision, only the procedure which allows the greatest benefit will be covered.

**Surgery**
**Reconstructive Surgery**

| | |
|---|---|
| **Network** | 80% of contracted rates after deductible. |
| **Out-of-Network** | 60% of the maximum allowable amount after deductible. |

The plan covers reconstructive surgery under the following conditions:

- To improve the function of a body part when the malfunction is the direct result of a birth defect, sickness, surgery to treat a sickness or accidental injury, or an accidental injury.
- To remove scar tissue on the neck, face or head, if scar tissue is due to sickness or an accidental injury.
- Following a mastectomy, as well as reconstruction of the other breast to produce a symmetrical appearance. Coverage also is provided for prostheses and for treatment of physical complications at all stages of the mastectomy, including lymphedemas.

**Surgery**
**Second and Third Surgical Opinions**

| | |
|---|---|
| **Network** | 80% of contracted rates after deductible. |
| **Out-of-Network** | 60% of the maximum allowable amount after deductible. |

Second and third surgical opinions are used to determine whether the surgery is medically necessary. The second or third opinion must be obtained from a board-certified surgeon who is not the surgeon originally scheduled to perform the surgery. Covered charges include:

- Charges for the surgical consultation.
- Charges for laboratory and x-ray examinations.
- Charges for the diagnostic procedures associated with the consultation.

## Therapy Treatments

After you pay the deductible, the plan can help pay covered charges for therapy treatments prescribed by a physician and provided by a licensed physical, occupational, speech, orthoptic or other therapist.

**Physical, Occupational, and Speech Therapy**

| | |
|---|---|
| **Network** | 100% after a $40 copayment, no deductible, for office visits; 80% of contracted rates, no deductible, for therapy performed in an outpatient facility; up to a maximum of 90 visits per calendar year (combined network and out-of-network visits for physical, occupational and speech therapies). |
| **Out-of-Network** | 60% of the maximum allowable amount after deductible for office visits or therapy performed in an outpatient facility; up to a maximum of 90 visits per calendar year (combined network and out-of-network visits for physical, occupational and speech therapies). |

**Physical Therapy**

Outpatient services for physical therapy are covered. The plan pays benefits only for therapy services given by a licensed or certified provider acting within the scope of that license or certification. Inpatient services for physical therapy are covered as inpatient hospital benefits. For additional benefits, see **Rehabilitation Therapy (inpatient) and Rehabilitation Therapy (outpatient)** in this section.

**Occupational Therapy**

Outpatient services for occupational therapy are covered. The plan pays benefits only for therapy services given by a licensed or certified provider acting within the scope of that license or certification. Inpatient services for occupational therapy are covered as inpatient hospital benefits. For additional benefits, see **Rehabilitation Therapy (inpatient)** and **Rehabilitation Therapy (outpatient**) in this section.

## Speech Therapy

The plan pays benefits for speech therapy only when the speech impediment or speech dysfunction results from injury, stroke, cancer, sickness or a congenital anomaly. For example, the services of a licensed speech therapist are covered to restore speech lost or impaired due to surgery, radiation therapy or other treatment that affects the vocal chords; cerebral thrombosis; brain damage due to accidental injury or organic brain lesion (aphasia); or accidental injury.

In addition, benefits are paid for services of a licensed speech therapist for treatment given to a child under age 26 whose speech is impaired due to one of the following conditions:

- Autism spectrum disorders.
- Pervasive developmental disorders.
- Development delay
- Cerebral palsy.
- Hearing impairment.

Major congenital anomalies that affect speech, such as, but not limited to, cleft lip and cleft palate.

## Orthoptic Therapy

| | |
|---|---|
| **Network** | 100% after a $40 copayment, no deductible, for office visits; 80% of contracted rates, no deductible, for therapy performed in an outpatient facility; up to a maximum of 30 visits per calendar year (combined network and out-of-network visits for orthoptic therapy). |
| **Out-of-Network** | 60% of the maximum allowable amount after deductible for office visits or treatment in an outpatient facility; up to a maximum of 30 visits per calendar year combined network and out-of-network visits for orthoptic therapy). |

Outpatient services for orthoptic therapy are covered. The plan pays benefits only for orthoptic therapy services given by a licensed or certified provider acting within the scope of that license or certification. Orthoptic therapy is an individualized treatment program prescribed to eliminate or improve conditions such as amblyopia (lazy eye), strabismus (crossed eyes), focusing, eyeteaming and tracking disorders. Inpatient services for orthoptic therapy are covered as inpatient hospital benefits.

# how the plan pays
# inter-plan programs

This section provides information about the inter-plan programs that may apply when you access care in a geographic area that is considered out-of-area from the claims administrator.

## Blue Cross and/or Blue Shield Providers

The claims administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as **Inter-Plan Programs**. Whenever you obtain healthcare services, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program and may include negotiated National Account arrangements available between the claims administrator and other Blue Cross and Blue Shield Licensees.

Typically, you may obtain care from healthcare providers that have a contractual agreement (in other words, are **participating providers**) with the local Blue Cross and/or Blue Shield Licensee in that geographic area (referred to as **Host Blue**). In some instances, you may obtain care from non-participating healthcare providers. The plan's payment practices in both instances are described in this section.

## BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, the claims administrator will remain responsible for fulfilling their contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services and the claim is processed through the BlueCard® Program, the amount you pay for covered healthcare services is calculated based on the lower of the following:

- The billed covered charges for your covered services.
- The negotiated price that the Host Blue makes available to the claims administrator.

Often, this **negotiated price** will consist of a simple discount, which reflects the actual price paid by the Host Blue to your healthcare provider. But sometimes it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and other credits or charges. Occasionally it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the claims administrator uses for your claim because they will not be applied retroactively to claims already paid.

# Value-Based Programs

## Value-Based Programs Overview

You may access covered services from providers that participate in a Host Blue Plan's Value-Based Program. Value-Based Programs may be delivered either through the Blue Card Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

## Value-Based Programs Administration

Under Value-Based Programs, a Host Blue Plan may pay providers for reaching agreed-upon cost/quality goals in the following ways: retrospective settlements, provider incentives, a share of target savings, care coordinator fees and/or other allowed amounts. The Host Blue Plan may pass these provider payments to the claims administrator, who will pass them onto the plan as either an amount included in the price of the benefit claim or an amount charged separately in addition to the benefit claim. When such amounts are included in the price of the benefit claim, the claim may be billed using one of the following pricing methods, as determined by the Host Blue Plan:

- **Actual Pricing.** The charge for Value-Based Programs incentives/Shared Savings settlements is part of the benefit claim. These charges are passed onto the plan via an enhanced provider fee schedule.
- **Supplemental Factor.** The charge for Value-Based Programs incentives/Shared Savings settlements is a supplemental amount that is included in the benefit claim as an amount based on a specified supplemental factor (for example, a small percentage increase in the benefit claim amount). The supplemental factor may be adjusted from time to time.

You will not bear any portion of the cost of Value-Based Programs except when a Host Blue Plan uses either average pricing or actual pricing to pay providers under Value-Based Programs.

## Care Coordinator Fees

Host Blue Plans may also bill the claims administrator for Care Coordinator Fees for provider services which may be included in individual claim billings through applicable care coordination codes from the most current editions of either Current Procedural Terminology (CPT) published by the American Medical Association (AMA) or Healthcare Common Procedure Coding System (HCPCS) published by the U.S. Centers for Medicare and Medicaid Services (CMS).

## Value-Based Programs under Negotiated Arrangements

If the claims administrator has entered into a Negotiated Arrangement with a Host Blue Plan to provide Value-Based Programs to plan participants, the claims administrator will follow the same procedures for Value-Based Programs administration and Care Coordination Fees as noted above.

## Non-Participating Health Care Providers Outside the Claims Administrator's Service Area

### Member Liability Calculation

When covered health care services are provided by non-participating health care providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating health care provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating health care provider bills and the payment the plan will make for the covered services as set forth in this paragraph.

### Exceptions

In certain situations, the claims administrator may use other payment bases, such as billed covered charges, the payment the plan would make if the health care services had been obtained within California, or a special negotiated payment, as permitted under the claims administrator's Inter-Plan Programs Policies, to determine the amount the plan will pay for services rendered by non-participating health care providers. In these situations, you may be liable for the difference between the amount that the non-participating health care provider bills and the payment the plan will make for the covered services as set forth in this paragraph.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a provider who is not part of an exclusive network arrangement, that provider's services will be considered non-network care (also referred to as *out-of-network*), and you may be billed the difference between the charge and the maximum allowable amount. You may call the customer service number on your ID card or go to **www.anthem.com/ca** for more information about such arrangements.

Providers available to you through the BlueCard Program have not entered into contracts with the claims administrator. If you have any questions or complaints about the BlueCard Program, please call the customer service telephone number listed on your ID card.

## Care Outside the United States — BlueCross BlueShield Global Core

Prior to travel outside the United States, call the customer service telephone number listed on your ID card to find out if your plan has BlueCross BlueShield Global Core benefits. Your coverage outside the United States is limited and the claims administrator recommends:

- Before you leave home, call the customer service number on your ID card for coverage details. You have coverage for services and supplies furnished in connection only with urgent care or an emergency when travelling outside the United States.
- Always carry your current ID card.
- In an emergency, seek medical treatment immediately.
- The BlueCross BlueShield Global Core Service Center is available 24 hours a day, seven days a week toll-free at 1-800-810-2583 or by calling collect at 804-673-1177. An assistance coordinator, along with a medical professional, will arrange a physician appointment or hospitalization, if needed.

### Payment Information

- **Participating BlueCross BlueShield Global Core hospitals.** In most cases, you should not have to pay upfront for inpatient care at participating BlueCross BlueShield Global Core hospitals except for the out-of-pocket costs you normally pay (non-covered services, deductible, copays, and coinsurance). The *hospital* should submit your claim on your behalf.

- **Physicians and/or non-participating hospitals.** You will have to pay upfront for outpatient services, care received from a physician, and inpatient care from a hospital that is not a participating BlueCross BlueShield Global Core hospital. Then you can complete a BlueCross BlueShield Global Core claim form and send it with the original bills to the BlueCross BlueShield Global Core Service Center. The return address is on the form.

### Claim Filing

- **Participating BlueCross BlueShield Global Core hospitals will file your claim on your behalf.** You will have to pay the hospital for the out-of-pocket costs you normally pay.
- **You must file the claim** for outpatient and physician care, or inpatient hospital care not provided by a participating BlueCross BlueShield Global Core hospital. You will need to pay the health care provider and subsequently send an international claim form with the original bills to the claims administrator.

### Additional Information About BlueCross BlueShield Global Core Claims

- You are responsible, at your expense, for obtaining an English-language translation of foreign country provider claims and medical records.
- Exchange rates are determined as follows:
  - For inpatient hospital care, the rate is based on the date of admission.
  - For outpatient and professional services, the rate is based on the date the service is provided.

### Claim Forms

International claim forms are available from the claims administrator, from the BlueCross BlueShield Global Core Service Center, or online at:

- **www.bcbsglobalcore.com**
- The address for submitting claims is on the form.

# expenses that aren't covered under the plan

The Medical PPO does not cover the following:

- Services or supplies provided during times you or your covered dependents were not covered under the plan.
- Services and supplies that do not meet the definition of a covered charge.
- Charges in excess of the plan's maximum allowable amount.
- Charges in excess of the contracted rate with respect to a network provider, or a provider with whom the claims administrator or Chevron Corporation has negotiated a contracted rate.
- Charges for services, supplies, procedures and treatments that are not medically necessary.
- Services provided by foreign and sign language interpreters.
- Diagnostic services, supplies, tests, or procedures (other than mammography) furnished by a Hospital or other diagnostic facility which are self-directed or ordered by a Provider affiliated with such diagnostic facility who is not actively involved in your medical care.
- Confinement, treatment, services or supplies given for, or related to, any of the following:
  - Abdominoplasty.
  - Liposuction.
  - Speech therapy for fluency disorders.
  - Chelation therapy, except to treat heavy metal poisoning.
  - Tobacco dependency, except as specifically covered by the Mental Health and Substance Abuse Plan or the Prescription Drug Program.
  - Massage therapy, including, but not limited to, Rolfing.
  - Membership costs for health clubs, purchase of home whirlpools, spas and saunas for any reason.
  - Tine test for tuberculosis.
  - Herbal medicine, holistic or homeopathic care, including, but not limited to, drugs, aromatherapy and ecological or environmental medicine.
  - Personal convenience or comfort items or general household goods, including, but not limited to, the purchase or rental of radios, TVs, telephones, first-aid kits, exercise equipment, air conditioners, humidifiers, food liquefiers, newspapers or bedside service tables, or the cost of meals for guests.
- Charges for broken appointments or for completing or processing claim forms, for telephone conversations for consultations or for Internet consultations.
- Cosmetic or reconstructive surgery or procedures, except reconstructive surgery that's specifically covered under the plan.

- Physical appearance:

  - Cosmetic surgery or treatment (surgery or treatment primarily to change appearances), whether or not for psychological or emotional reasons, including confinement, treatment, services or supplies, including:
    - Cosmetic procedures.
    - Pharmacological regimens.
    - Nutritional procedures or treatments (including gastric bypass).
    - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
    - Skin abrasion procedures performed as a treatment for acne.
  - Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure. Note that replacement of an existing breast implant is considered reconstructive rather than cosmetic if the initial breast implant followed a mastectomy.
  - Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility and diversion or general motivation.
  - Weight reduction or control, whether or not they are under medical supervision (such as Jenny Craig™ and Weight Watchers™). Membership costs for weight-loss clinics and similar programs and special foods, food supplements, liquid diets, diet plans or other related products.
  - Wigs, toupees, hair transplants, hair weaving, or any drug used in connection with baldness, regardless of the reason for the hair loss, including congenital alopecia (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury).
  - Medical and surgical treatment of excessive sweating (hyperhidrosis).
  - Obesity surgery (unless accompanied by a diagnosis of morbid obesity).

- Treatment of benign gynecomastia (abnormal breast enlargement in males).

- Medical and surgical treatment for snoring and appliances that prevent snoring (except when provided as a part of treatment for documented obstructive sleep apnea).

- Custodial care.

- Eye refractions (vision screenings), eyeglasses, contact lenses and other vision-related supplies, services and procedures, except as specifically covered by the vision program or unless required by an accidental injury. Surgical procedures to correct refraction errors of the eyes (for example, LASIK or PRK), including any confinement, services or supplies given in connection with, or related to, the surgery, are excluded (see the Basic Vision section).

- Hearing aids and cochlear implants (except as specifically covered under the Medical PPO) and dental prosthetic appliances, other than when required in connection with temporomandibular joint dysfunction (TMJ), or the fitting of any of these supplies, unless required by an accidental injury (see Dental Care under What the Plan Pays in this section).

- Services provided by any person who is a member of your immediate family or who resides in your home.

- Charges for any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- Charges incurred by a sperm or egg donor.
- Elective amniocentesis or other tests performed solely to learn the sex of the unborn child.
- Home delivery of a newborn child.
- Treatment in a U.S. government or agency hospital. However, the reasonable cost incurred by the U.S. or one of its agencies for inpatient medical care and treatment given by a hospital of the uniformed services may be covered under the plan. The cost of this inpatient medical care and treatment will be covered if the charges for the care and treatment are otherwise covered under this plan and the care and treatment were provided to one of the following:

  - A person retired from the uniformed services.
  - A family member of a person who is retired from the uniformed services.
  - A family member of a person who is active in the uniformed services.
  - A family member of a deceased member of the uniformed services.

- Expenses that you, yourself, are not legally required to pay. However, the reasonable cost incurred by the U.S. for medical care and treatment given to a veteran by the U.S. or one of its agencies may be covered under these plans. The cost of the care and treatment will be covered if:

  - The veteran does not have a service-related disability.
  - Charges for the care and treatment are otherwise covered under the plan.

- Treatment or services provided by a government facility or physician, or payable under a government plan or program, except as required by law.
- Treatment of an injury or other loss that results from a 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.
- Charges for services that aren't considered acceptable and appropriate by the general medical community.
- Services given by a pastoral counselor (except as provided under Hospice Care in What the Plan Pays in this section).
- Private-duty nursing services while confined in a hospital or other facility.

- Services or supplies in connection with organ or tissue transplants, except as specifically provided by the plan (see Organ and Tissue Transplants in What the Plan Pays in this section).

- Education, training, and bed and board in an institution that is primarily a school, or other institution for training or a place of rest, or a domicile for the aged.

- Auxiliary items normally available without a prescription, even though they're recommended by a physician (including items such as posture chairs, hot tubs, exercise bicycles and other exercise equipment).

- Routine physical exams required for insurance, licensing, employment, school, camp or other nonpreventive purposes.

- Any tests required for a marriage license.

- Equipment for environmental control or general household use (such as air conditioners and food liquefiers).

- Immunizations for travel outside the U.S. or for occupational requirements.

- Payments for which you're reimbursed or are eligible to receive reimbursement as a result of any award or settlement from a third party for medical expenses resulting from an act or failure to act of the third party — including reimbursements under no-fault automobile insurance — unless you or your dependent agrees to reimburse the plan when damages are recovered from the third party.

- Examinations or treatment ordered by a court in connection with legal proceedings, unless these examinations or this treatment otherwise qualifies as covered charges.

- Products purchased for nutrition purposes, including, but not limited to:

  - Megavitamin and nutrition-based therapy.
  - Nutritional counseling for either individuals or groups, including weight-loss programs, health clubs and spa programs, are excluded except in cases where the nutritional counseling is medically necessary, related to a condition that is covered by the plan, and performed by a registered dietician in individual sessions (benefits are limited to three sessions per lifetime for each medical condition). Some examples of medically necessary nutritional counseling are when the patient is diagnosed with diabetes mellitus, coronary artery disease, congestive heart failure, severe obstructive airway disease, gout, renal failure, phenylketonuria, and hyperlipidemias.
  - Enteral feedings and other nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low-fat, cholesterol), oral vitamins or oral minerals (however, these items may be covered if the formula or supplement is the sole source of nutrition or treats a specific inborn error of metabolism, is prescribed and is not available over the counter).

- Medical supplies and appliances:
  - Devices used specifically as safety items or to affect performance in sports-related activities.
  - Prescribed or non-prescribed medical supplies and disposable supplies, including:
  - Elastic stockings.
  - Ace bandages.
  - Gauze and dressings.
  - Syringes and diabetic test strips (covered under Prescription Drug Program).
  - Orthotic appliances that straighten or reshape a body part (including some types of braces).
  - Tubings and masks, except when used with covered durable medical equipment.
  - Foot care (except when needed for severe systemic disease):
  - Routine foot care (including the cutting or removal of corns and calluses), nail trimming, cutting or debriding.
  - Hygienic and preventive maintenance foot care, including cleaning and soaking the feet.
  - Applying skin creams in order to maintain skin tone.
  - Other services that are performed when there is not a localized illness, injury or symptom involving the foot.
  - Treatment of flat feet.
  - Treatment of subluxation of the foot.
  - Shoe orthotics (except when needed for severe systemic disease).

- Treatment for mental health or substance abuse problems (covered under the Mental Health/ Substance Abuse Plan).

- Charges for preventive services that are not medically necessary and are not considered covered preventive care under the plan.

- Charges you're not required to pay.

- Dental care, except care that's specifically covered under the plan.

- Any drugs, unless provided while confined in a hospital or unless they are injectable drugs that are routinely or customarily administered by a physician or registered nurse (R.N.) in the provider's office.

- Any type of therapy, service or supply, including, but not limited to, spinal manipulations by a chiropractor or other physician, for the treatment of a condition that ceases to be therapeutic treatment, as determined by Anthem and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

- Non-rehabilitative educational care.

- Treatment or services that aren't prescribed as necessary by a physician.

- Charges for which a claim for benefits isn't filed within six months (by June 30) following the year in which the covered charge is incurred.

- Transportation, other than the transportation services specifically provided by the plan.

- Sensitivity training or educational training therapy or treatment for an education requirement.

- Services provided while the recipient is covered under another health care plan to which Chevron contributes or has made contributions on your behalf.

- Services, supplies, or treatments (and related confinements) that the Claims Administrator determines to be experimental services or investigational services or unproven Hospital charges for a private room in excess of the hospital's regular daily rate for semiprivate room accommodations.

- Services of a physician who is in attendance but who is not providing face-to-face care or who is a standby surgeon to a surgical procedure (except as specifically covered under the Medical PPO).

- Skilled nursing facility charges for a private room in excess of the skilled nursing facility's regular daily rate for semiprivate room accommodations.

- Services and supplies in connection with an occupational injury or sickness. An occupational injury or sickness is an injury or sickness that is covered under a workers' compensation act or similar law. For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the workers' compensation act or similar law, had that coverage been elected.

# clinical review

The plan includes Clinical Review procedures to help you get appropriate medical care in a cost-effective setting.

You or your provider must contact Anthem before you can qualify for full plan benefits for the following kinds of care:

- All inpatient hospital stays (including emergency).
- Inpatient childbirth (if stay exceeds 48 hours for normal delivery and 96 hours after a cesarean delivery).
- Breast reduction and reconstruction (except after cancer surgery).
- Reconstructive surgery and procedures.
- Organ and tissue transplants (the facility needs to be approved by Anthem).
- Acute inpatient rehabilitation therapy.
- Skilled nursing facility care.
- Private-duty nursing or visiting nurses.
- Home health care.
- Home infusion therapy.
- Hospice care (the hospice agency needs to be approved by Anthem).
- Durable medical equipment (if purchase or cumulative rental cost exceeds $1,000).
- Accident dental services.
- Alternative treatments.
- Gender Identity Disorder/Dysphoria benefits
- Participation in a clinical trial

It's your responsibility to make sure Anthem is called if you or a family member needs hospitalization or any of the other treatments described in this Clinical Review section. It is not necessary to call Anthem if you or a family member needs outpatient surgery.

After you call Anthem, a health care professional will discuss the proposed treatment with your physician and advise both you and your physician of Anthem's decision regarding coverage. In some cases, Anthem may suggest that your physician consider an alternative course of treatment.

When you notify Anthem, it does not imply that the plan will pay full benefits or any benefits at all for a particular claim. Even though a provider prescribes treatments or services, Anthem determines if the treatments or services are covered by the plan and are medically necessary.

If treatment is not considered medically necessary, the plan will not pay benefits. If you don't call within the required time period, the percentage of benefits paid for covered charges may be reduced to 60

percent in network or 60 percent out of network, after you satisfy the deductible, or may not be payable at all.

For more information about Clinical Review appeals, see Appealing Clinical Review Decisions in this section.

## Musculoskeletal Surgeries

For employees enrolled in the plan who are scheduled for a knee, hip, back or spine surgery greater than seven days out, they are required to contact 2nd MD for a second opinion. If a second opinion is not obtained from 2nd MD prior to one of these surgeries, the employee will be responsible for an additional $400 of out-of-pocket costs, whether or not the annual deductible has been met. The employee is only responsible for obtaining the second opinion.

If your physician recommends the surgery be scheduled in seven days or less, it will be considered an emergency surgery and not subject to the requirement to obtain a second opinion through 2nd MD.

This requirement is for employees only. For information on 2nd MD program eligibility please review the Health Decision Support SPD.

## Inpatient Hospital Stay

Call Anthem at least two business days before you're admitted, or within two business days after an emergency hospital admission.

- **Before you're hospitalized: Anthem** reviews your case with your physician and advises on the anticipated number of days of hospitalization that may be needed.

- **While you're hospitalized: Anthem** checks with your physician to see how your treatment is progressing, and may arrange for additional care, such as visiting nurse services at home, or care in a rehabilitation center or skilled nursing facility.

**To qualify for full plan benefits, you must notify Anthem.** If you don't contact Anthem before you're hospitalized, the percentage of benefits paid by the plan for covered charges for hospital room and board charges will be reduced to 60 percent if in network or 60 percent if out-of-network, after you satisfy the deductible. If Anthem determines that hospitalization isn't medically necessary, no plan benefits will be paid for your hospital stay. In this case, you or your provider can appeal the decision. Even if you and your physician follow the plan's Clinical Review procedures, the plan won't cover any charges for services that aren't medically necessary, as determined by Anthem. If you have a question about covered charges, contact Anthem.

## Inpatient Childbirth (if stay exceeds federally mandated guidelines)

The following applies for both network and out-of-network childbirth services. No approval or preauthorization is needed from Anthem for maternity admissions. 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).

You must call Anthem for a length of stay in excess of these periods. If you don't notify Anthem about an extended stay (prior to the extended stay), the percentage of benefits paid for covered charges for the additional days is reduced to 60 percent if in network or 60 percent if out-of-network, after you satisfy the deductible.

## Reconstructive Surgery and Procedures

The plan can help pay for reconstructive surgery required to repair a birth defect or damage due to an accidental injury or disfiguring disease. To receive benefits for reconstructive surgery, you must notify Anthem at least two business days before you receive reconstructive surgery.

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.

If you don't contact Anthem at least two business days before you receive reconstructive surgery, the percentage of benefits paid for covered charges may be reduced to 60 percent in network or 60 percent out-of-network, after you satisfy the deductible.

## Organ and Tissue Transplants

Anthem notification is required for all organ and tissue transplant services. You need to contact Anthem as soon as transplantation is a possibility. If you don't contact Anthem in advance, the percentage of benefits paid for covered charges for organ and tissue transplant services may be reduced to 60 percent in network or 60 percent out-of-network, after you satisfy the deductible. For the transplant expense to be covered by the plan, *all* of the following must apply:

- The transplant must be medically necessary.
- The transplant must be performed by approved physicians.

The transplant must be performed at an approved facility or at a Blue Distinction Center for liver, heart, heart-lung, lung, kidney, kidney-pancreas, liver-small bowel, pancreas, small bowel or bone marrow transplants, including autologous bone marrow transplants, peripheral stem-cell replacement and similar procedures.

The plan has specific guidelines regarding benefits for transplant services. For example, the transplant must be done at a facility approved or designated by Anthem. For information about these guidelines, contact Anthem at the telephone number on your ID card.

Cornea transplants are not covered by Anthem under the transplant program. Instead, they are covered as any other surgery.

**Transportation and Lodging**
Anthem will assist the patient and family with travel and lodging arrangements.

You or your network physician must notify Anthem before the time a pre-transplantation evaluation is performed at a transplant center. If you do not notify Anthem, and if the services are not performed at a facility approved by Anthem, the percentage of benefits paid for covered charges may be reduced to 60 percent in network or 60 percent out-of-network, after you satisfy the deductible

## Acute Rehabilitation (inpatient)
If your physician prescribes inpatient rehabilitation, you must notify Anthem at least two business days before this care starts. If you don't call Anthem within this time period the percentage of benefits paid for covered charges for inpatient rehabilitation may be reduced to 60 percent in network or 60 percent out-of-network, after you satisfy the deductible.

## Skilled Nursing Facility Care
If your physician prescribes care in a skilled nursing facility, you must notify Anthem at least two business days in advance. If you don't call Anthem within this time period the percentage of benefits paid for covered charges for skilled nursing facility care may be reduced to 60 percent in network or 60 percent out-of-network, after you satisfy the deductible. Custodial care isn't covered by the plan, even if it's prescribed by a physician and provided by a nurse.

## Private-Duty Nursing or Visiting Nurses
If your physician prescribes private-duty nursing care outside the hospital, you must notify Anthem at least two business days before this care starts. If you don't call Anthem within this time period the percentage of benefits paid for covered charges for private-duty nursing may be reduced to 60 percent in network or 60 percent out-of-network, after you satisfy the deductible. Custodial care isn't covered by the plan, even if it's prescribed by a physician and provided by a nurse.

## Home Health Care
If your physician recommends home health care services, you must call Anthem at least two business days before services begin. If you don't call Anthem within this time period the percentage of benefits paid for covered charges may be reduced to 60 percent in network or 60 percent out-of-network, after you satisfy the deductible.

Anthem decides if skilled home health care is required by reviewing both the skilled nature of the service and the need for physician-directed medical management. A service is not determined to be skilled simply because there is not an available caregiver. Anthem also must approve the home health care agency before benefits are payable.

## Home Infusion Therapy
If your physician recommends home infusion therapy for you or your dependent, you must notify Anthem. If you fail to make the call or if you call less than two business days before receiving services, the percentage of benefits paid for covered charges for any subsequently approved benefits may be reduced to 60 percent in network or 60 percent out-of-network, after you satisfy the deductible.

## Hospice Care
If your physician recommends hospice care, you must call Anthem before services begin. If you don't call Anthem in advance, the percentage of benefits paid for covered charges may be reduced to 60 percent in network or 60 percent out-of-network, after you satisfy the deductible. Anthem also must approve the hospice agency or facility before benefits are payable.

## Durable Medical Equipment (If purchase or cumulative rental cost exceeds $1,000)

If your physician prescribes the use of durable medical equipment, and the cost of purchase or cumulative rental of any single item is more than $1,000, you must seek approval from Anthem. Anthem will decide if the equipment should be purchased or rented. To receive plan benefits, you must purchase or rent the durable medical equipment from the vendor that Anthem identifies. When the purchase or rental cost exceeds $1,000 and you don't call Anthem before obtaining the equipment, no plan benefits are payable. Certain durable medical equipment requires periodic recertification.

## Accident Dental Services

After an accident, the plan will pay benefits for dental services when *all* of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a doctor of dental surgery (D.D.S.) or a doctor of medical dentistry (D.M.D.).
- Benefits are available only for treatment of a sound, natural tooth. The physician or dentist must certify that the injured tooth was one of the following:
  - A virgin or unrestored tooth.
  - A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss and no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must meet both of the following criteria:

- Started within three months of the accident.
- Completed within 12 months of the accident.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an accident. Benefits are not available for repairs to teeth that are injured as a result of such activities.

You don't need to notify Anthem before emergency treatment. However, if treatment requires inpatient hospitalization, you must call Anthem within two business days after being admitted; otherwise, the percentage of benefits paid for covered charges may be reduced to 60 percent in network or 60 percent out of network after you satisfy the deductible.

For follow-up (nonemergency) treatment, you must notify Anthem as soon as possible, but no later than two business days before follow-up treatment occurs. When you provide notification, Anthem can verify that the service is medically necessary.

## Alternative Treatments

In very limited cases, the plan may pay for *alternative medical treatment*. Reasonable charges for services or supplies that aren't otherwise covered charges can be considered if all of the following apply:

- They are determined by Anthem to be a medically reasonable alternative, having a cost equal to or lower than the current or projected course of treatment.
- They don't involve a permanent improvement to the member's or patient's residence.
- They are prescribed for the treatment of the patient's disease or condition as an aid to recovery and are not primarily related to non-rehabilitative education or custodial care.

Alternative treatment determinations are made by Anthem and must be approved in advance.

## Gender Identity Disorder/Dysphoria

Before beginning treatment, you or your physician must notify Anthem to request a Clinical Review at least two business days before you're admitted to the hospital for network or out-of-network hospitalization. If you don't follow the Clinical Review procedures, the percentage of benefits paid for covered charges will be reduced to 60 percent in network and 60 percent out of network, after you satisfy the deductible.

## Participation in Clinical Trials

Before beginning participation, you or your physician must notify Anthem to request a Clinical Review at least two business days before you're admitted to the hospital for network or out-of-network hospitalization. If you don't follow the Clinical Review procedures, the percentage of benefits paid for covered charges will be reduced to 60 percent in network and 60 percent out of network, after you satisfy the deductible

## Appealing Health Care Review Decisions

If you contact Anthem for Clinical Review, and Anthem determines that a treatment or test isn't medically necessary or isn't covered by the plan for other reasons, you and your provider can appeal this decision.

To understand how appeals work, see the Initial Claim Review and Decision section. Depending on the type of claim, you have a specific time frame to request an appeal from Anthem and Anthem has a specific time frame to respond to your appeal.

Anytime you notify Anthem in advance for authorization before you receive treatment, it is considered a preservice claim.

If your appeal results in another denial, you and your provider can go ahead with the proposed treatment, but your claim for plan benefits will be denied because the treatment wasn't approved in advance. In this case, you can appeal the denial of your claim.

# medical claims and appeals

This section describes how to file a claim for Medical PPO benefits and the claim review and appeals process that is followed whenever you submit a claim for benefits. You should be aware that Anthem has the right to request repayment if they overpay a claim for any reason. 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.

Except as required under a Qualified Medical Child Support Order or under a state Medicaid law, your benefits, rights and interest under the Medical PPO shall not be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary. Benefits under the Medical PPO may not be assigned, transferred or in any way made over to another party. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, garnish, execute or levy upon, or otherwise dispose of any right to Medical PPO benefits shall be void. A direction to pay a provider is not an assignment of any right under the Medical PPO or of any legal or equitable right to institute any court proceeding. This provision shall also apply to non-network providers who accept assignments of claims. When the claims administrator in its discretion directs payment to a non-network provider, you or your dependent remains the sole beneficiary of the payment, and the non-network provider does not thereby become a beneficiary under the Medical PPO.

## How to File a Medical Claim

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, you generally will first pay for the services and supplies you receive. You must then file a claim for benefits as explained here. Anthem will generally send reimbursement to you (not the out-of-network provider). You are responsible for paying your out-of-network provider.

If you go to an out-of-network provider for care, you should file a medical claim as soon as you incur a covered charge, even if you haven't yet paid your deductible. Claim forms are available by clicking on **Forms** at **www.anthem.com/ca** or by calling Anthem. Claim forms also are available from the HR Service Center or on the Benefits Connection website at **hr2.chevron.com.**

You must file the claim in a format that contains the following information:

- Your name and address.
- Patient's name and date of birth.
- Subscriber number stated on your ID card.
- Name, address, telephone number and tax identification number of the provider of the service(s).
- Diagnosis from the physician.
- Itemized bill from your provider that includes the standard insurance billing codes typically referred to as current procedural terminology (CPT) codes.
- Date the injury or sickness began.
- Statement indicating whether you are or you are not enrolled in coverage under any other health insurance plan or program. If you are enrolled in other coverage, you must include the name of the other claims administrator(s).

The address of the claims administrator is:

Anthem
Chevron
P.O. Box 60009
Los Angeles, CA 90060

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. This time limit does not apply if you are legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

If you provide written authorization to allow direct payment to a provider, all or a portion of any eligible covered charges due to a provider may be paid directly to the provider instead of being paid to you. Anthem will not reimburse third parties who have purchased or been assigned benefits by physicians or other providers.

If your claim is denied, or if Anthem 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 further below.

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 book.

**Note:** For information on how to file a prescription drug claim, please see the **Prescription Drug Coverage** chapter of this summary plan description. For information on how to file a basic vision claim, please see the **Chevron Vision Program** summary plan description.

## Initial Claim Review and Decision

When you file a claim, the claims administrator (Anthem 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 nonurgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or which, in the opinion of your physician, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

- **Preservice 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 by the Clinical Review Program before you receive such medical services.

- **Postservice claim:** Any claim that is not a preservice claim — that is, does not require Clinical Review Program 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.***

| Time Limits | Types of Claims | | |
|---|---|---|---|
| | **Urgent Care Health Claims** | **Pre-service Health Claims** | **Post-service 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.<br>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.<br>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.<br>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 non-urgent circumstance, your request will be considered a new claim and decided according to pre-service or post-service 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 the next section below.

**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 in this section, Time Limits for Processing Claims (see Plan Notice of Initial Claim Decision row).

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. 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 officially appeal a denial of a claim,*** you can call the claims administrator (see the Summary Chart under Administrative Information section) 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 Anthem and the time limits that apply to the different types of medical appeals.

**Time Limits for Processing Appeals**

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

| Time Limits | Types of Claims: Urgent Care Health Claims | Pre-service Health Claims | Post-service 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. | 1. **Not later than 15 days** after receiving an appeal, if the plan allows two levels of appeal.<br>2. **Not later than 30 days** after receiving an appeal, if the plan allows one level of appeal. | 1. **Not later than 30 days** after receiving an appeal, if the plan allows two levels of appeal.<br>2. **Not later than 60 days** after receiving an appeal, if the plan allows one level of 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**.** | **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.

## Where to Send Your First Appeal

All of the claims administrators offer one appeal. In addition, Anthem offers a second appeal, except that there is only one level of appeal for an urgent care claim. Send your appeal to the claims administrator:

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

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 first 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 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 neither an individual who was consulted in connection with the denial of the claim that is the subject of the appeal, nor the subordinate of such individual.

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

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

### Notice of Decision on First Appeal

If, on the first appeal, the claims administrator determines that your explanation and additional information support the payment of your claim, the claims administrator will process and pay your claim.

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 first 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 first 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 first appeal, the claims administrator upholds the denial of your claim and the claims administrator allows two levels of appeal, you may file a second appeal within 90 days after receiving the notice of denial of your first appeal.

Note that there is only one level of internal appeal for an urgent care claim.

### Second Appeal

The Medical PPO allows two levels of appeal (except for urgent care claims) for medical benefits. 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 physician or specialist determines that your explanation and additional information support the payment of your claim, the claims administrator will process and pay your claim.

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. If applicable, 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 Anthem by phone or by mail:

- 1-844-627-1632
- Anthem Appeals │P.O. Box 54159│Los Angeles, CA │90054-0159

## 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 Medical PPO 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 provided under the Chevron Vision Program.

## 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 Chevron Dental Plan and the Prescription Drug Program).

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

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

If your Medical PPO is the secondary payer, the combined benefit from both plans won't total more than your Medical PPO'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 Medical PPO. 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 Medical PPO pays the remaining covered charges, if any, up to plan limits after the deductible. For example, assume the husband has surgery that requires a three-day hospital stay, the total cost for his surgery is $10,000, all of these charges are covered under the Medical PPO, and he has already met the $1,000 deductible. Having used a network provider and hospital under the Medical PPO, he is eligible for a 80 percent reimbursement (or $8,000). But the primary plan pays $7,000, so the Medical PPO pays only $1,000.

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

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

If you're covered by the Medical PPO 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, or to Chevron's hospital indemnity and critical illness 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 Chevron Dental Plan in case of accidental injury to teeth.

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

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

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

**Note:** Coordination of benefits does not apply to benefits payable under any private accident or health insurance plans, or to Chevron's hospital indemnity and critical illness 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 Chevron Dental Plan in case of accidental injury to teeth.

## Coordinating with Medicare

**Active employees:** If you're an active employee, and you or an enrolled dependent is eligible for federal Medicare due to age or disability, the Medical PPO is generally the primary payer and Medicare is the secondary payer.

**Note:** If you or your dependent has Medicare coverage because of end-stage renal disease, Medicare is primary. However, for the first 30 months of Medicare eligibility, the Medical PPO is the primary payer and Medicare is secondary. After 30 months, Medicare becomes primary.

**Disability Leave**

If you're on leave of absence and receiving Long-Term Disability benefits, the government no longer considers you an active employee. If you become eligible for Medicare due to disability, Medicare becomes the primary payer of benefits for you and any Medicare-eligible dependents. **You can remain enrolled in the Medical PPO, but you must also enroll in Medicare Part B. The Medical PPO will assume enrollment in both Medicare Part A and Part B and will pay claims as though you have both parts. If you aren't enrolled in Part B, you will be responsible for a large part of the claims cost.**

**When you retire**

When you retire, Medicare will become the primary payer for medical benefits for post-65 Medicare-eligible retirees and their post-65 Medicare-eligible eligible dependents. When you decide to retire, you need to take action four months in advance of your retirement date. All benefits-eligible retirees must enroll in Chevron retiree health benefits and/or the Retiree HRA Plan upon reaching certain enrollment milestones. You must also enroll your eligible dependents at certain enrollment milestones. **Retirement from Chevron is an important enrollment milestone for retiree health benefits for you and your eligible dependents.** Failure to take timely action could result in a gap in medical coverage, or worse, cause you and your dependents to miss this important enrollment milestone entirely.

If you or any eligible dependents are age 65 or older (post-65), Medicare Part A and Part B are required to enroll in individual health coverage through OneExchange and to activate your Retiree HRA Plan. Coverage is not automatic. Start **enrollment in Medicare Part A and Medicare Part B** at least four months in advance of your retirement for any Medicare-eligible participants that are not already enrolled in Medicare. Next, **call OneExchange** three months in advance of your retirement date to understand post-65 health benefit options and begin the enrollment process.

# basic vision coverage

If you and your eligible dependents enroll in the Medical PPO you are also automatically enrolled in the Chevron Vision Program for **basic vision** coverage. VSP insures the basic vision benefits under the Vision Program. Information about this basic vision coverage is *not* included in this summary plan description; see the **Chevron Vision Program** summary plan description for more information.

- For information about the benefit as it applies to active employees, see the **Chevron Vision Program** summary plan description on **hr2.chevron.com**.
- For information about the benefit as it applies to pre-65 retirees, see the **Chevron Vision Program** chapter of the **Chevron Pre-65 Retiree Health Benefits** summary plan description on **hr2.chevron.com/retiree.**

# prescription drugs
## chevron medical PPO

Express Scripts is the claims administrator of prescription drug benefits under the Medical PPO. You and your eligible dependents are covered by the Chevron Prescription Drug Program if you are enrolled in the Medical PPO. This section describes the prescription drug benefits under the plan.

# introduction

- Express Scripts is the claims administrator of the Prescription Drug Program. Express Scripts has a network of retail pharmacies and a home delivery pharmacy program.

- You and your eligible dependents are covered by the Chevron Prescription Drug Program if enrolled in the Medical PPO.

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

- The Prescription Drug Program also features a list of preferred brand-name drugs designed to help keep costs down.

# prescription drug benefit overview

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

| Program Feature | Retail Pharmacy (network) | Retail Pharmacy (out-of-network) ** | Home Delivery Service |
|---|---|---|---|
| **Deductible** (separate from medical deductible) | $150 individual<br>$300 family | $150 individual<br>$300 family | No deductible |
| **Annual Out-of-Pocket Maximum** (separate from medical plans' annual out-of-pocket maximum) | $1,800 individual<br>$3,600 family | $1,800 individual<br>$3,600 family | $1,800individual<br>$3,600 family |
| | **After you pay the deductible, the plan pays:** | **After you pay the deductible, the plan pays:** | **The plan pays:** |
| **Generic Drugs** | 100% after you pay a $5 copayment. | 100% of network price after you pay a $5 copayment. | 100% after you pay a $15 copayment. |
| **Preferred Brand-Name Drugs*** | 80%<br>You pay a $15 minimum. | 80% of network price<br>You pay a $15 minimum. | 85%<br>You pay a $35 minimum. |
| **Nonpreferred Brand-Name Drugs*** | 70%<br>You pay a $30 minimum. | 70% of network price<br>You pay a $30 minimum. | 75%<br>You pay a $75 minimum. |
| **Supply Limit** | Up to a 30-day supply. | Up to a 30-day supply. | Up to a 90-day supply. |
| **Refills Maintenance Drugs** | 40% beginning with second refill of maintenance drug. | 40% of network price beginning with second refill of maintenance drug. | Refills allowed. |
| **Specialty Maintenance Drugs** | Refills at retail – 0%. | Refills at retail – 0%. | Refills allowed. |

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

****Network Pharmacies vs. Out-of-Network Pharmacies**
When you use a retail pharmacy that is out-of-network (or a network pharmacy is unable to verify your eligibility), you pay your coinsurance percentage or copayment (depending on the type of drug prescribed) plus the difference between the network discounted price and the out-of-network price for your prescription.

# prescription drug deductible

Your deductible is the amount of covered prescription drug charges for combined retail network and out-of-network benefits you pay each calendar year before the plan begins paying its share of those charges. The Prescription Drug Program deductible is separate from the deductible for the Medical PPO

| Prescription Drug Deductible | Amount |
|---|---|
| You Only | $150 |
| You and Family (two or more) | $300 |

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

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

- Amounts you pay for prescriptions through the home delivery pharmacy program.
- The difference you pay between the cost of the brand-name drug and its generic equivalent unless your Physician provides the medical reason that the generic version of the drug will not work.
- 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 card at a network pharmacy).
- Charges for services or supplies that aren't covered under the Prescription Drug Program.

# prescription drug out-of-pocket maximum feature

Under this feature, after your covered out-of-pocket costs reach the specified amount for the coverage tier, the Prescription Drug Program pays 100 percent of all covered charges until the end of the calendar year. The Prescription Drug Program out-of-pocket maximum is separate from the out-of-pocket maximum for the Medical PPO

| 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 out-of-pocket maximum for prescription drugs, nor are they part of the 100 percent reimbursement after you reach your out-of-pocket maximums:

- Your Prescription Drug Program deductible expenses.
- The medical and mental health services combined deductible.
- The difference you pay between the cost of the brand-name drug and its generic equivalent unless your physician provides the medical reason that the generic version of the drug will not work.
- 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 card at a network pharmacy).
- The additional coinsurance amount you pay when you go to a retail network pharmacy after the first refill of a prescription for maintenance medication.
- Charges for services or supplies that aren't covered under the Prescription Drug Program.

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# covered medication

## Qualification Requirements

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

- It must be prescribed on an outpatient basis by a physician.
- 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 and 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. Furthermore, Chevron has the right to determine which drugs will be covered, limited or excluded under the Prescription Drug Program.

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

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

- Certain physician prescribed medications for preventive care as required by the Patient Protection and Affordable Care Act with no deductible. Contact Express Scripts for questions about which drugs are covered. Examples of the medications are:

  – Generic over-the-counter aspirin to prevent cardiovascular events (age limits apply)

  – Generic over-the-counter aspirin for preeclampsia

  – Generic over-the-counter and generic drug Folic Acid (women through age 50)

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

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

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

## Managed Prior Authorization and Dose Quantity Management (DQM)

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

## Preferred Drug Step Therapy Program

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

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

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

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

## Medical Channel Management

Certain specialty drugs are covered by the Prescription Drug Program only if they are ordered through the Express Scripts Specialty Pharmacy, Accredo. They will not be covered if supplied by your physician or another pharmacy. Examples of some 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 drug. The current list of prescription drugs subject to Medical Channel Management can be obtained at any time from Express Scripts.

## 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

## Home Delivery Order 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.

# drugs that aren't covered

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

- Any prescription drugs not listed on the Express Scripts National Preferred Formulary; provided, however, that use of these drugs may be approved through a formulary exception.
- 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 Medical PPO).
- 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 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 physician or dispensed more than one year after your physician 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.
- Refills of specialty maintenance medications purchased at a retail pharmacy.
- Nonsedating antihistamines.
- Most compound drugs (except pediatric compounds).
- 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 claims.

## When You Go to a Network Pharmacy

You can fill prescriptions for up to a 30-day supply of covered medication at any network pharmacy. Here's how:

1. Show your prescription ID card to the pharmacist or provide your Express Scripts ID number when you hand in your prescription. Generally, after you meet your deductible, you will pay the following for most drugs:

   - $5 for generic drugs.
   - 20 percent of the discounted cost for preferred brand-name drugs.
   - 30 percent of the discounted cost for nonpreferred brand-name drugs.

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

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

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

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

3. To encourage you to use the home delivery pharmacy services when you need maintenance medication, you will pay 60 percent of the cost if you go to a pharmacy for the second refill of a prescription for maintenance medication, with a $5 minimum payment per generic drug and a $15 minimum payment per preferred brand name drug, or $30 minimum for non-preferred brand-name drug, up to the total cost of the drug. This plan provision doesn't apply to covered charges for smoking deterrents and fluoride supplements.

## When You Go to a Pharmacy That's Out-of-Network

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 pharmacist the full price of the prescription and file a claim form.

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

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

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

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

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

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

## Filing a Claim

If your prescription is filled at an out-of-network pharmacy or at a network pharmacy, but the pharmacist is unable to verify your coverage, you must pay the full price for your medication and send in a completed claim form to request reimbursement of covered charges. If your claim is denied, you'll be notified in writing. For more information, see the Prescription Drug Claims section.

# home delivery pharmacy program

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 without a deductible. You should use this part of the program when you need maintenance medication.

When you use the home delivery pharmacy to fill a prescription, you will generally pay the following amounts for each 90-day (or less) supply:

- $15 for generic drugs (up to the total cost of the drug).
- 15 percent for preferred brand-name drugs, with a $35 minimum (up to the total cost of the drug).
- 25 percent for nonpreferred brand-name drugs, with a $75 minimum (up to the total cost of the drug).
- To encourage the use of more cost-effective generics, if you choose a brand-name drug when a generic version of the drug is available, or if your physician specifies that you receive a brand-name drug by writing "Dispense as Written" on your prescription, you will pay the $15 generic copayment plus the difference between the brand-name and the generic version unless your physician provides the medical reason that neither the generic version of the drug, or other covered drugs that treat the same condition will work. In that case, you will not pay the difference between the cost of the brand-name drug and the generic drug

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

**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. Allow a minimum of two to three weeks for new prescriptions.

**How to Order Medication by Mail**

- Ask your physician for a prescription for a 90-day supply of medication, with up to three refills. You can order a smaller supply, but you'll still pay the same minimum amount. If you need medication immediately, ask your physician to write another prescription for a 14-day supply and have it filled at a pharmacy. If your physician 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 physician determine that the new drug is effective, send the other prescription to the home delivery pharmacy.
- Your physician can fax your prescriptions to Express Scripts. Ask your physician 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 mail your prescriptions to Express Scripts. Please allow a minimum or 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. You can also request home delivery order forms and envelopes by visiting **www.Express-Scripts.com**.

- Check your physician's prescription form to make sure it includes the correct dosage, your physician'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 an additional cost.

**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. 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 physician for a new prescription.

**Note:** You can pay your share of home delivery pharmacy costs with a personal check or money order, or you can charge it on your MasterCard, Visa, American Express, Diners or Discover credit card by writing your charge account number and expiration date on the order form. If you do not use a credit card or provide another form of payment when you submit your order, Express Scripts will fill your prescription and send it to you as long as the order is no more than $100. (Express Scripts will bill you later.) If your order is over $100, Express Scripts will not fill your prescription without payment. For an estimate of the cost of your prescription, visit **www.Express-Scripts.com** or call Express Scripts Member Services.

# 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 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 (the benefits under this option will be lower than if you use one of the other options).

# prescription drug claims and appeals

This section describes how to file a claim for outpatient prescription drug benefits and the claim review and appeals process that is followed whenever you submit a claim for benefits. You also should be aware that Express Scripts has the right to request repayment if it overpays a claim for any reason. 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.

## How to File a Prescription Drug Claim

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

However, if your prescription is filled at an out-of-network pharmacy or at a network pharmacy but your request is denied (for example, your ID card is rejected), you pay the full price charged for your medication and send in a completed claim form to request reimbursement of covered charges. You must file your claim form within one year after your prescription is filled. (Please note that this is different from the time period to file claims under the Medical PPO) Otherwise, no benefits will be payable for that prescription. If you don't file a proper claim with Express Scripts within this time frame, benefits will be denied.

To request a claim form, you can call Express Scripts Member Services or you can obtain forms from Express Scripts' website at **www.Express-Scripts.com**. Claim forms are also available on the Benefits Connection website at **hr2.chevron.com** or from the HR Service Center. When you fill out the claim form, use your full name and member ID number located on your Express Scripts ID card. Attach the original receipt from the pharmacy. The receipt must contain the following information:

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

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

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

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.

**Note:** For information on how to file a prescription drug claim, please see the **Prescription Drug Coverage** chapter of this summary plan description. For information on how to file a medical benefit claim, please see the Medical PPO - **Medical Coverage** chapter of this summary plan description. For information on how to file a basic vision claim, please see the **Chevron Vision Program** summary plan description.

## 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 physician requests "Dispense as Written." 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 physician 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 prescription submitted to a home delivery pharmacy. If additional information is required to make the determination, the prescribing physician 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 physician, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If your coverage request is an urgent care claim, Express Scripts will make a determination on a prescription presented at a retail network pharmacy or submitted to a home delivery pharmacy not later than 72 hours after receiving the initial claim, if it was properly made and no additional information is required. If additional information is required to make the determination, the prescribing physician will be contacted by fax or phone with a request for the necessary information. Your physician 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 physician has not requested "Dispense 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 that you can request a copy of it (the rule, guideline, protocol or other similar item) free of charge.

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

## How to File an Appeal

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

### Time Limits for Processing Prescription Drug Appeals

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

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

## First Appeal

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

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

Your written first appeal should include the following information:

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

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

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

If your urgent care claim is denied, you have the right to request an urgent appeal of the adverse determination. Urgent appeal requests may be oral or written. You or your physician 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. 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 Express Scripts considers, relies upon or generates any additional or new evidence during the appeal or if Express Scripts will base an impending denial upon any new or additional rationale, Express Scripts will provide such evidence or rationale as soon as possible in advance of the date the decision is due in order to give you a reasonable opportunity to respond prior to the decision being issued.

## Notice of Decision on First Appeal

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

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

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

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

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

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

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

## Second Appeal

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

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

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

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

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

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

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

## Time Limits and Procedures for Processing Your Second Appeal

Upon receipt of your second appeal, Express Scripts will review the claim again and make a decision based on all comments, documents, records and other information you've submitted, without regard to whether such information was submitted or considered in the initial benefit determination. Express Scripts will make its determination on your second appeal in accordance with the time limits shown in the chart, Time Limits for Processing 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 Express Scripts considers, relies upon or generates any additional or new evidence during the appeal or if Express Scripts will base an impending denial upon any new or additional rationale, Express Scripts will provide such evidence or rationale as soon as possible in advance of the date the decision is due in order to give you a reasonable opportunity to respond prior to the decision being issued.

### Notice of Decision on Second Appeal

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

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

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

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

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

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

Express Scripts is the named fiduciary that serves as the 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 for which a second appeal is requested.

## Requesting an External Review

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

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

You or your authorized representative can request an external review in writing or verbally to Express Scripts by following instructions in your denial letter or contacting Express Scripts at:

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

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

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

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

Within one business day of completing the preliminary review, Express Scripts will notify you in writing of the name and contact information for the IRO reviewing your request for external review. The notice will state 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 its 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

1-800-753-2851
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.

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

Coordination of benefits is a feature used to determine how much the Prescription Drug Program pays when you or one of your dependents is covered by more than one group prescription drug plan and incur covered charges for prescription drugs. This feature is designed to prevent overpayment of benefits. This section does not apply to medical coverage under the Medical PPO or to the basic vision coverage under the Chevron Vision Program.

## 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. The sum of the benefits paid from each plan will not exceed the actual expense incurred.

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

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

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

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

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

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

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

If you're covered by the prescription drug program 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, or to Chevron's hospital indemnity and critical illness plans. Also, it does not apply to benefits payable under any other group insurance or medical plan maintained by Chevron. However, the plan does coordinate benefits with the Dental Plan in case of accidental injury to teeth.

## 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, or to Chevron's hospital indemnity and critical illness plans. Also, it does not apply to benefits payable under any other group insurance or medical plan maintained by Chevron. However, the plan does coordinate benefits with the Dental Plan in case of accidental injury to teeth.

## Coordinating with Medicare

**Active employees:** If you're an active employee and you or an enrolled dependent is eligible for federal Medicare due to age or disability, the prescription drug program is generally the primary payer and Medicare is the secondary payer.

**Note:** If you or your dependent has Medicare coverage because of end-stage renal disease, Medicare is primary. However, for the first 30 months of Medicare eligibility, the Medical PPO is the primary payer and Medicare is secondary. After 30 months, Medicare becomes primary.

# how to file a claim for eligibility

If you have been denied participation or if you believe you are entitled to credit for health and welfare eligibility service in the Omnibus Health Care Plan, this section describes how to file a written claim with the plan administrator.

If you have a question regarding your eligibility to participate in the Omnibus Health Care Plan or if you believe you are entitled to credit for health and welfare eligibility service, contact the HR Service Center. If you are not satisfied with the outcome, you can file a claim by following the procedures described below. If you have been denied participation or if you believe you are entitled to credit for health and welfare eligibility service in the Omnibus Health Care Plan, you can file a written claim with the plan administrator. Include the grounds on which your claim is based and any documents, records, written comments or other information you feel will support the claim. Address your written correspondence to:

Chevron Corporation
Omnibus Health Care Plan Administrator
Chevron Human Resources Service Center
P.O. Box 18012
Norfolk, VA 23501

If you file a claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan, the plan administrator will send you a decision on the claim within 90 days after the claim is received. However, if there are special circumstances that require additional time, the plan administrator will advise you that additional time is needed and then will send you a decision within 180 days after the claim is received. If the claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan is denied (in whole or in part), the plan administrator will send you a written explanation that includes:

- Specific reasons for the denial, as well as the specific Omnibus Health Care Plan provisions or Chevron policy on which the denial is based.
- A description of any additional information that could help you complete the claim and reasons why the information is needed.
- Information about how you can appeal the denial of the claim.
- A statement explaining your right to file a civil lawsuit under Section 502(a) of ERISA if your appeal is denied.

## Appeal Procedures for Denied Claims

**Regarding Eligibility to Participate or Credit for Health and Welfare Eligibility Service**

If your claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan is denied, in whole or in part, and you want to appeal the denial, you must file an appeal within 90 days after you receive written notice of the denial of your claim. The appeal must be in writing, must describe all of the grounds on which it is based and should include any documents, records, written comments or other information you feel will support the appeal. Before submitting the appeal, you can review and receive, at no charge, copies of Omnibus Health Care Plan documents, records and other information relevant to your claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan. The Review Panel will provide you with a written response to the appeal and will either reverse the earlier decision and permit participation or provide credit for health and welfare eligibility service in the Omnibus Health Care Plan, or it will deny the appeal. If the appeal is denied, the written response will contain:

- The specific reasons for the denial and the specific Omnibus Health Care Plan provisions or Chevron policy on which the denial is based.
- Information explaining your right to review and receive, at no charge, copies of Omnibus Health Care Plan documents, records and other information relevant to your claim for participation or for credit for health and welfare eligibility service in the Omnibus Health Care Plan.
- A statement explaining your right to file a civil lawsuit under section 502(a) of ERISA.

The Review Panel doesn't have the authority to change Omnibus Health Care Plan provisions or Chevron policy or to grant exceptions to the Omnibus Health Care Plan rules or Chevron policy. For appeals regarding participation or credit for health and welfare eligibility service in the Omnibus Health Care Plan, address your written correspondence to:

Review Panel
Omnibus Health Care Plan
P.O. Box 6075
San Ramon, CA 94583-0775

The Review Panel may require you to submit (at your expense) additional information, documents or other material that it believes is necessary for the review.

You will be notified of the final determination of the appeal within 60 days after the date it's received, unless there are special circumstances that require additional time. You will be advised if more time is needed, and you'll then receive the final determination within 120 days after the appeal is received. If you do not receive a written decision within 60 or 120 days (whichever applies), you can take legal action.

# other plan information

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

# administrative information

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

## Employer Identification Number (EIN)

The employer identification number is 94-0890210.

## Plan Sponsor and Plan Administrator

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

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

1-888-825-5247

**Chevron Corporation Medical Plan (Medical PPO Plan)**
**(Administered by Anthem)**
(Also automatically enrolled in the Prescription Drug Program for prescription drug coverage and the Chevron Basic Vision Program for basic vision coverage.) This plan is part of the Omnibus Health Care Plan.

**Plan number:** 560

**Claims Administrator:**
Anthem Group Claims – Chevron | Group #174209 |
P.O. Box 60009 | Los Angeles, CA 90060

www.anthem.com/ca

**Type of Administration:** Contract Administration

**Type of Plan:** Medical Benefit

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

**Plan number:** 560

**Claims Administrator:**
Express Scripts | One Express Way | St. Louis, MO 63121 |
www.Express Scripts.com

**Type of Administration:** Contract Administration

**Type of Plan:** Medical (Prescription Drug) Benefit

**Chevron Corporation Basic Vision Program**
This program is part of the Omnibus Health Care Plan.

**Plan number:** 560
**Claims Administrator: Vision Service Plan (VSP)**
**Type of Administration: Insurer Administration**
**Type of Plan:** Medical (Vision) Benefit

**Chevron Corporation Omnibus Health Care Plan**

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

**Before-Tax Contribution Plan**

**Plan number:** 721
**Type of Administration:** Company Administered
**Type of Plan:** Health Contribution (Section 125 Cafeteria Plan)

## Agent for Service of Legal Process

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

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

You can also serve process on a plan by serving the plan administrator.

If you have a dispute with a health maintenance organization (HMO), a dental health maintenance organization (DHMO), 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 the HMO, DHMO, or VSP, as applicable.

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

## Administrative Power and Responsibilities

Chevron Corporation has the discretionary authority to control and manage the administration and operation of the 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.

## Plan Amendments and Changes

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

## Participating Companies

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

## Collective Bargaining Agreements

If a union represents you, you're eligible for the Omnibus Health Care Plan, provided both of the following apply:

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

Generally, Chevron's collective bargaining agreements don't mention specific plans or benefits. They merely provide that Chevron will extend to its employees who are members of the collective bargaining unit, the employee benefit 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 plan is incorrect, you should notify the appropriate claims administrator in writing. If it's found that you or a beneficiary wasn't paid benefits you or your beneficiary was entitled to, the plan will pay the unpaid benefits.

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

## Recovery of Overpayments

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

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

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

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

## Plan Year

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

## No Right to Employment

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

## Future of the Plans

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

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

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

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

# HIPAA

The Plan will use protected health information (PHI) as permitted or required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A copy of the Plan's Notice of Privacy Practices can be obtained at **hr2.chevron.com/docs/health_privacy.pdf.**

# your ERISA rights

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

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

## Receive Information About Your Plan and Benefits

You have the right to:

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

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

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

## Continue Group Health Plan Coverage

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

**If You Have a Pre-existing Condition**

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

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

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

Chevron Corporation
Human Resources Service Center
P.O. Box 18012
Norfolk, VA 23501

## 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 a civil lawsuit under Section 502(a) of ERISA in a federal court. In such a case, the court can require the plan administrator to provide the materials and pay you up to $147 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 and/or plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

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

- Calling the Employee Benefits Security Administration publications hotline at 1-866-444-3272.
- Logging on to the Internet at **www.dol.gov/ebsa/publications/main.html.**

## Filing a Lawsuit

You can file a lawsuit to recover a benefit under a plan provided the action is commenced within the lesser of the applicable statute of limitations period or four years after the occurrence of the loss for which a claim is made. You can file a lawsuit 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 plan's 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 can also serve process on a plan by serving the plan administrator.

If you have a dispute with a health maintenance organization (HMO), a dental health maintenance organization (DHMO), 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 the HMO, DHMO, or VSP, as applicable.

# other legislation that can affect your benefits

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

## Newborns' and Mothers' Health Protection Act of 1996

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

## Reconstructive Surgery and Procedures

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

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

You may need to contact Anthem before any reconstructive surgery to make sure you qualify for full benefits. See the Clinical Review section for more information.

## 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.

**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 January 1, 2017. Contact your State for more information on eligibility –**

| **ALABAMA – Medicaid** | **GEORGIA – Medicaid** |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | Website: http://dch.georgia.gov/medicaid<br>- Click on Health Insurance Premium Payment (HIPP)<br>Phone: 404-656-4507 |
| **ALASKA – Medicaid** | **INDIANA – Medicaid** |
| The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility:<br>http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx | Healthy Indiana Plan for low-income adults 19-64<br>Website: http://www.hip.in.gov<br>Phone: 1-877-438-4479<br>All other Medicaid<br>Website: http://www.indianamedicaid.com<br>Phone 1-800-403-0864 |
| **ARKANSAS – Medicaid** | **IOWA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Website: http://www.dhs.state.ia.us/hipp/<br>Phone: 1-888-346-9562 |
| **COLORADO – Medicaid** | **KANSAS – Medicaid** |
| Medicaid Website: http://www.colorado.gov/hcpf<br>Medicaid Customer Contact Center: 1-800-221-3943 | Website: http://www.kdheks.gov/hcf/<br>Phone: 1-785-296-3512 |
| **FLORIDA – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Website: http://flmedicaidtplrecovery.com/hipp/<br>Phone: 1-877-357-3268 | Website:<br>http://www.dhhs.nh.gov/oii/documents/hippapp.pdf<br>Phone: 603-271-5218 |
| **KENTUCKY – Medicaid** | **NEW JERSEY – Medicaid and CHIP** |
| Website: http://chfs.ky.gov/dms/default.htm<br>Phone: 1-800-635-2570 | Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Medicaid Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 |
| **LOUISIANA – Medicaid** | **NEW YORK – Medicaid** |
| Website:<br>http://dhh.louisiana.gov/index.cfm/subhome/1/n/331<br>Phone: 1-888-695-2447 | Website:<br>http://www.nyhealth.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **MAINE – Medicaid** | **NORTH CAROLINA – Medicaid** |
| Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711 | Website: http://www.ncdhhs.gov/dma<br>Phone: 919-855-4100 |

| MASSACHUSETTS – Medicaid and CHIP | NORTH DAKOTA – Medicaid |
|---|---|
| Website: http://www.mass.gov/MassHealth<br>Phone: 1-800-462-1120 | Website:<br>http://www.nd.gov/dhs/services/medicalserv/medicaid/<br>Phone: 1-844-854-4825 |
| **MINNESOTA – Medicaid** | **OKLAHOMA – Medicaid and CHIP** |
| Website: http://mn.gov/dhs/ma/<br>Phone: 1-800-657-3739 | Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 |
| **MISSOURI – Medicaid** | **OREGON – Medicaid** |
| Website:<br>http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 | Website:<br>http://healthcare.oregon.gov/Pages/index.aspx<br>http://www.oregonhealthcare.gov/index-es.html<br>Phone: 1-800-699-9075 |
| **MONTANA – Medicaid** | **PENNSYLVANIA – Medicaid** |
| Website:<br>http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084 | Website: http://www.dhs.pa.gov/hipp<br>Phone: 1-800-692-7462 |
| **NEBRASKA – Medicaid** | **RHODE ISLAND – Medicaid** |
| Website:<br>http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx<br>Phone: 1-855-632-7633 | Website: http://www.eohhs.ri.gov/<br>Phone: 401-462-5300 |
| **NEVADA – Medicaid** | **SOUTH CAROLINA – Medicaid** |
| Medicaid Website: http://dwss.nv.gov/<br>Medicaid Phone: 1-800-992-0900 | Website: http://www.scdhhs.gov<br>Phone: 1-888-549-0820 |
| **SOUTH DAKOTA - Medicaid** | **WASHINGTON – Medicaid** |
| Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 | Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program<br>Phone: 1-800-562-3022 ext. 15473 |
| **TEXAS – Medicaid** | **WEST VIRGINIA – Medicaid** |
| Website: http://gethipptexas.com/<br>Phone: 1-800-440-0493 | Website:<br>http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx<br>Phone: 1-877-598-5820, HMS Third Party Liability |
| **UTAH – Medicaid and CHIP** | **WISCONSIN – Medicaid and CHIP** |
| Website:<br>Medicaid: http://health.utah.gov/medicaid<br>CHIP: http://health.utah.gov/chip<br>Phone: 1-877-543-7669 | Website:<br>https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf<br>Phone: 1-800-362-3002 |
| **VERMONT– Medicaid** | **WYOMING – Medicaid** |
| Website: http://www.greenmountaincare.org/<br>Phone: 1-800-250-8427 | Website: https://wyequalitycare.acs-inc.com/<br>Phone: 307-777-7531 |

| VIRGINIA – Medicaid and CHIP | |
|---|---|
| Medicaid Website:<br>http://www.coverva.org/programs_premium_assistance.cfm<br>Medicaid Phone: 1-800-432-5924<br>CHIP Website:<br>http://www.coverva.org/programs_premium_assistance.cfm<br>CHIP Phone: 1-855-242-8282 | |

To see if any other states have added a premium assistance program since January 1, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor U.S. Department of Health and Human Services
Employee Benefits Security Administration

**www.dol.gov/ebsa**
1-866-444-EBSA (3272)

Centers for Medicare & Medicaid Services
**www.cms.hhs.gov**
1-877-267-2323, Menu Option 4, Ext. 61565

**Paperwork Reduction Act Statement**
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

# third party responsibility

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

If you and/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 and/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 and/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 and/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 and/or your covered dependent, no-fault coverage, and uninsured and/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 and/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 and/or your covered dependent has any rights to it.

**Creation of Constructive Trust**
You and/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 and/or your covered dependent, you and/or your covered dependent's attorney, an account or trust set up for you and/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 and/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 and/or your covered dependent agrees to timely notify the health plans of:

- The possibility that benefits paid by the health plans may be the responsibility of a third party.

- The submission of any claim or demand letter, the filing of any legal action, the request for any alternative dispute resolution process, or the commencement date of any trial or alternative dispute resolution process, regarding or related to any property that may be subject to the health plans' rights (1) of subrogation, reimbursement and restitution, (2) to an equitable lien by contract, and (3) as beneficiary of a constructive trust.

- Any agreement that any property that may be subject to the health plans' rights (1) of subrogation, reimbursement and restitution, (2) to an equitable lien by contract, and (3) as beneficiary of a constructive trust will be paid to or on behalf of you and/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 and/or your covered dependent), the health plans have no obligation to do so.

## Recovery of Overpayments

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

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

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

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

# 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 medical plan coverage, prescription drug coverage, dental coverage, mental health and substance abuse coverage, the Healthy Heart Program, Health Decision Support, or Executive Physical Program.

# who's eligible for continuation coverage

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

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

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

# qualifying events

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

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

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

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

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

## Special Rule for Bankruptcy of the Employer

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

## Chevron Must Give Notice of Some Events

Chevron has the responsibility to notify the HR Service Center, 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 **Eligibility** chapter, **Eligible Children** and **Other Dependents** sections for details on eligibility. You must notify Chevron within 31 days after the first of the month coinciding with or following the termination of your domestic partnership or any final determination by the Social Security Administration that a qualified beneficiary is disabled or is no longer disabled. If you don't notify Chevron within the above time limits, your dependents won't be eligible for continuation coverage.

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

The following information should be included in the notice:

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

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

You should provide your notice to the Chevron HR Service Center. 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 18012
Norfolk, VA 23501

If you or a family member does not provide this notice to Chevron's HR Service Center within the time limit specified above, you and your dependents will lose eligibility for continuation coverage with respect to that qualifying event.

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

## Electing Continuation Coverage

When the HR Service Center is notified that one of these events has occurred, the HR Service Center will in turn notify you that you have the right to elect continuation coverage. Under the law, you have 60 days from the date you would lose Chevron health plan coverage because of one of these events, or the date your continuation coverage election notice is sent to you, whichever is later, to inform the HR Service Center 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.

# how to pay for continuation coverage

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

Regular monthly COBRA payments by mail should be payable to the **Chevron HRSC** and must be mailed to:

Conduent HR Services for Chevron Corporation
P.O. Box 382064
Pittsburgh, PA 15251-8064

Online payment of COBRA premiums from the Benefits Connection website is not currently available. However, you may arrange for a direct debit from your personal bank account, as described below.

## Direct Debit Payment Option with the HR Service Center

You can automatically pay the HR Service Center for your COBRA coverage with direct debit from any U.S. checking or savings account. Once set up, you will no longer receive a monthly invoice or need to write a check. Chevron does not charge maintenance fees for this option, and the HR Service Center can debit any bank account in the United States. You can enroll in direct debit after you have paid your first full invoice. To enroll for direct debit:

- Call the HR Service Center and request a **Direct Debit Authorization Form**. You can also access this form on the Benefits Connection website.
- Forms received and processed by the HR Service Center before the first business day of the month will take effect for the following month's coverage.
  - Example: If you return a direct debit form before November 1, direct debit will typically take effect for your December 2017 premium payment.
- When your direct debit is setup, you will receive a confirmation notice that provides the date of the first debit from your account. **You must continue to pay by check until your confirmation notice is received.**
- The direct debit deduction occurs no sooner than the fifteenth of each month. If the fifteenth falls on a weekend or bank holiday, the debit will be made on or after the first business day following the fifteenth.
- The direct debit applies to the payment for the next month's coverage period.
  - Example: The direct debit on November 15 applies to the premium payment for the December coverage period.

# when continuation coverage starts

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

## How Long Continuation Coverage Lasts

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

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

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

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

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

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

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

## Disability extension of 18-month period of continuation coverage

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

- Your continuation coverage qualifying event was an employee's termination of employment (for any reason other than gross misconduct) or a reduction in hours so that the employee (and you) was no longer eligible for Chevron health care benefits.
- The disability started at some time before the 60th day of continuation coverage and lasts at least until the end of the 18-month period of continuation coverage.
- A copy of the Notice of Award from the Social Security Administration is provided to the HR Service Center within 60 days of receipt of the notice and before the end of the initial 18 months of continuation coverage.
- If the disabled qualified beneficiary elects continuation coverage, you must pay an increased premium of 150 percent of the monthly cost of health plan coverage that's continued, beginning with the 19th month of continuation coverage.

## Second qualifying event extension of 18-month period of continuation coverage

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

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

## Extension Due to Medicare Eligibility

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

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

# when continuation coverage ends

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

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

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

# important considerations when you leave chevron

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

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

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

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

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

### Request an Intent to Retire Package

Contact the HR Service Center and request an **Intent to Retire** package as early as three months prior to your retirement date for information and instructions regarding health, welfare and pension benefits. Go to the **Retirement Resources** information on **hr2.chevron.com** at any time for more information about retirement, how it affects your Chevron benefits, and enrollment instructions and deadlines.

### What if I Die?

Please see the **If You Die: Important Considerations chapter** for more information about access to survivor health benefits for your eligible dependents in the event you die while participating in Chevron retiree health benefits.

## 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.

# if you die: important considerations

This section provides an overview of what happens to medical benefits for your eligible dependents if you die.

# what happens to health coverage

**In all cases, your survivor(s) must take action to report your death to the HR Service Center within 31 days of your death to remain eligible for coverage.** If a surviving spouse, surviving domestic partner or surviving dependent child misses the enrollment deadline, they become permanently ineligible for future Chevron health benefits and/or the Retiree HRA Plan. Eligibility will not be reinstated.

## If enrolled in Chevron *employee* group health coverage

Your eligible surviving spouse, surviving domestic partner or surviving dependent child must be enrolled in Chevron employee benefits on the date of your death to qualify for survivor coverage or COBRA continuation coverage. If you are an eligible employee enrolled in Chevron employee benefits at the time of your death, your *enrolled* dependents are eligible for any one of the following:

- **COBRA continuation coverage.**
  Your survivors are only eligible to elect COBRA coverage for the plans in which they are enrolled at the time of your death. See the **COBRA and Continuation Coverage** chapter of this summary plan description for more information about this coverage.

- **Chevron survivor health coverage.**
  - **Pre-65 eligible survivors** can participate in the Chevron group health coverage offered to pre-65 eligible retirees. See the **Chevron Pre-65 Retiree Health Benefits** summary plan description on **hr2.chevron.com/retiree** for a description of pre-65 health benefits.
  - **Post-65 eligible survivors** can participate in the individual medical, prescription drug, dental and vision coverage offered to Chevron retirees through OneExchange. Post-65 eligible surviving dependents are also eligible to participate in the Retiree HRA Plan. See the **Chevron Post-65 Retiree Health Benefits** summary plan description on **hr2.chevron.com/retiree** for a description of post-65 health benefits and the Chevron Retiree HRA Plan.

**Your survivor(s) must take action to report your death to the HR Service Center within 31 days of your death to remain eligible for coverage.** If a surviving spouse, surviving domestic partner or surviving dependent child misses the enrollment deadline, they become permanently ineligible for future Chevron health benefits and/or the Retiree HRA Plan. Eligibility will not be reinstated.

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 and the Retiree HRA Plan (if applicable). Coverage or eligibility will not be reinstated.

### If enrolled in Chevron COBRA or Chevron subsidized COBRA coverage

Your survivor(s) must take action to report your death to the HR Service Center within 31 days of your death to remain eligible for coverage. If you — the Chevron eligible retiree — die while covered under Chevron COBRA or subsidized COBRA coverage:

- **Chevron COBRA continuation coverage.**
  If your eligible surviving spouse, surviving domestic partner or surviving dependent child are also enrolled in Chevron COBRA coverage on the date of your death, your surviving dependents can continue their current COBRA coverage for the plans for which they are enrolled as your dependents on the date of your death. *Your surviving dependents are not eligible for Chevron survivor health coverage and/or the Retiree HRA. This means Chevron health coverage for surviving dependents ends permanently when their COBRA coverage period ends.*

- **Chevron *subsidized* COBRA continuation coverage.**
  If your eligible surviving spouse, surviving domestic partner or surviving dependent child are also enrolled in Chevron *subsidized* COBRA coverage on the date of your death, your surviving dependents can continue their current subsidized COBRA coverage until the end of the subsidized period for the plans for which they are enrolled as your dependents on the date of your death. *However, if your surviving dependent chooses to remain on COBRA coverage beyond the subsidized period, they will become permanently ineligible for future Chevron survivor health benefits and/or the Retiree HRA Plan. Eligibility will not be reinstated.*

- **Chevron survivor health coverage.**
  - **Pre-65 eligible survivors** can participate in the Chevron group health coverage offered to pre-65 eligible retirees. To remain eligible for survivor coverage, pre-65 eligible survivors must contact the HR Service Center within 31 days of the date of your death (or within 31 days of the date when subsidized COBRA coverage ends, if applicable). See the **Chevron Pre-65 Retiree Health Benefits** summary plan description on h**r2.chevron.com/retiree** for a description of pre-65 health benefits. If a surviving spouse, surviving domestic partner or surviving dependent child misses the enrollment deadline, they become permanently ineligible for future Chevron health benefits and/or the Retiree HRA Plan. Eligibility will not be reinstated.

  - **Post-65 eligible survivors** can participate in the individual medical, prescription drug, dental and vision coverage offered to Chevron retirees through OneExchange. Post-65 eligible surviving dependents are also eligible to participate in the Retiree HRA Plan. See the **Chevron Post-65 Retiree Health Benefits** summary plan description on **hr2.chevron.com/retiree** for a description of post-65 health benefits and the Chevron Retiree HRA Plan.
    - Medicare Part A and Part B is required to enroll in health coverage through OneExchange and to activate the Retiree HRA Plan.
    - To remain eligible for survivor coverage**,** post-65 eligible survivors must contact **OneExchange** within 31 days of the date of your death. They must also call the **HR Service Center** within 31 days of the date of your death to activate the Retiree HRA Plan.
    - If your post-65 eligible survivors are currently enrolled in Chevron **subsidized COBRA coverage** and wish to remain enrolled until the end of the subsidized period, they must contact OneExchange **three months** in advance of the subsidized COBRA end date to understand and begin the post-65 individual health coverage enrollment process. Failure to timely enroll through OneExchange could result in a gap in coverage. They must also call the HR Service Center within **31 days** of the date subsidized COBRA ends to activate the Retiree HRA Plan.

If a surviving spouse, surviving domestic partner or surviving dependent child misses an enrollment deadline, they become permanently ineligible for future Chevron health benefits and/or the Retiree HRA Plan. Eligibility will not be reinstated.

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 and the Retiree HRA Plan (if applicable). Coverage or eligibility will not be reinstated.

### If *not enrolled* in health coverage

Your dependents are **not** eligible for Chevron COBRA or continuation or survivor coverage if any of the following apply:

- If, on the date of your death, you were not enrolled in Chevron employee coverage, Chevron retiree coverage, Chevron COBRA coverage, Chevron subsidized COBRA coverage, or another employer's group health coverage.
- If, on the date of your death, **your eligible dependents** were not enrolled as a dependent under your health coverage.

### If enrolled in Chevron *retiree* health benefits

If you are a Chevron eligible retiree and die while covered under Chevron retiree health benefits, your eligible surviving spouse, surviving domestic partner or surviving dependent child must be enrolled in Chevron retiree health benefits on the date of your death to qualify for survivor coverage or COBRA continuation coverage. If you are an eligible retiree enrolled in the health benefits offered to Chevron eligible retirees on the date of your death, your *enrolled* dependents are eligible for either one of the following:

- **COBRA continuation coverage.**
  Your survivors are only eligible to elect COBRA coverage for the plans in which they are enrolled on the date of your death.
  - See the **COBRA and Continuation Coverage** chapter of the **Chevron Pre-65 Retiree Health Benefits** summary plan description on **hr2.chevron.com/retiree** for more information about COBRA coverage for pre-65 retiree health coverage.
  - See the **COBRA and Continuation Coverage** chapter of the **Chevron Post-65 Retiree Health Benefits** summary plan description on **hr2.chevron.com/retiree** for more information about COBRA coverage for the Retiree HRA Plan.
  - COBRA and Continuation Coverage does not apply to the post-65 individual health plans offered through OneExchange.

- **Chevron survivor health coverage.**
  - **Pre-65 eligible survivors** can participate in the Chevron group health coverage offered to pre-65 eligible retirees. See the **Chevron Pre-65 Retiree Health Benefits** summary plan description on **hr2.chevron.com/retiree** for a description of pre-65 health benefits.
  - **Post-65 eligible survivors** can participate in the individual medical, prescription drug, dental and vision coverage offered to Chevron retirees through OneExchange. Post-65 eligible surviving dependents are also eligible to participate in the Retiree HRA Plan. See the **Chevron Post-65 Retiree Health Benefits** summary plan description on **hr2.chevron.com/retiree** for a description of post-65 health benefits and the Chevron Retiree HRA Plan.

**Your survivor(s) must take action to report your death to the HR Service Center within 31 days of your death to remain eligible for coverage.** If a surviving spouse, surviving domestic partner or surviving dependent child misses the enrollment deadline, they become permanently ineligible for future Chevron health benefits and/or the Retiree HRA Plan. Eligibility will not be reinstated.

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 and the Retiree HRA Plan (if applicable). Coverage or eligibility will not be reinstated.

### If enrolled in another employer's group health coverage

If you are a Chevron eligible retiree and die while covered under another employer's group health plan, eligible dependents that are also covered under your group health plan on the date of your death can enroll in Chevron survivor health coverage.

- **Pre-65 eligible survivors** can participate in the Chevron group health coverage offered to pre-65 eligible retirees. See the **Chevron Pre-65 Retiree Health Benefits** summary plan description on **hr2.chevron.com/retiree** for a description of pre-65 health benefits.
- **Post-65 eligible survivors** can participate in the individual medical, prescription drug, dental and vision coverage offered to Chevron retirees through OneExchange. Post-65 eligible surviving dependents are also eligible to participate in the Retiree HRA Plan. See the **Chevron Post-65 Retiree Health Benefits** summary plan description on **hr2.chevron.com/retiree** for a description of post-65 health benefits and the Chevron Retiree HRA Plan.

An **employer group health plan** is defined as an employee health benefit plan established or maintained by an employer or by an employee organization (such as a union), or both, that provides medical care for participants or their dependents directly or through insurance, reimbursement, or otherwise. Retiree health insurance from a former employer or union or COBRA are not considered coverage based on current employment.

**Your survivor(s) must take action to report your death to the HR Service Center within 31 days of your death to remain eligible for coverage.** If a surviving spouse, surviving domestic partner or surviving dependent child misses the enrollment deadline, they become permanently ineligible for future Chevron health benefits and/or the Retiree HRA Plan. Eligibility will not be reinstated.

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 and the Retiree HRA Plan (if applicable). Coverage or eligibility will not be reinstated.

# making changes to survivor health benefits

Once enrolled, survivors can make benefit changes during:

- Chevron's open enrollment period for COBRA participants.
- Chevron's open enrollment period for pre-65 participants.
- Medicare's Annual Enrollment Period (AEP) for post-65 Medicare-eligible participants.

Survivors can also make changes during the year, when there is a qualifying life event (the change must be consistent with the qualifying life event as defined by Chevron or Medicare, as applicable).

- **For COBRA and pre-65 participants,** Contact the HR Service Center within 31 days of the date of the qualifying life event to make benefit changes.
- **For post-65 participants,** contact OneExchange within 31 days of the date of the qualifying life event to make benefit changes.

In all cases, there are some exceptions to the types of changes survivors are permitted to make, as follows:

- **Survivors cannot add additional dependents.** If a survivor adds an additional dependent to coverage, health coverage and/or participation in the Retiree HRA Plan will be canceled. (Up to 36 months of COBRA continuation coverage becomes available for health coverage only.) Exception: An eligible retiree/employee's dependent child who is born within nine months of the date of the eligible retiree/employee's death can be added to health coverage as long as the surviving spouse or domestic partner is enrolled in Chevron pre-65 group health coverage and the newborn is added to coverage as a dependent within 31 days of the date of birth.
- **If a survivor drops all health care coverage,** the survivor and any existing, enrolled dependents become permanently ineligible for future Chevron health plan coverage and the Retiree HRA Plan (if applicable). Coverage or eligibility will not be reinstated.
- **If a survivor drops an existing, enrolled dependent,** the dependent becomes permanently ineligible for future Chevron health plan coverage and the Retiree HRA Plan (if applicable). Coverage or eligibility will not be reinstated.

# cost of survivor health benefits

### COBRA Continuation Coverage

If your enrolled dependent(s) elects **COBRA continuation coverage**, they must pay the entire cost of each applicable plan plus a 2 percent administrative fee.

### Survivor Coverage

Chevron may pay a portion of the cost of survivor coverage. Contact the HR Service Center or OneExchange for information as it pertains to your situation.

# how long survivor health benefits last

Survivor coverage for a surviving spouse or domestic partner can continue until:

- The survivor dies.
- The survivor cancels coverage.
- The survivor does not make timely premium payments.
- Survivor coverage can continue if the survivor remarries or enters into a new domestic partner relationship, but the new spouse or domestic partner or any other new dependents cannot be added to any Chevron health benefit. If the survivor wants to add the new spouse or other new dependent to the plan, survivor coverage and/or the Retiree HRA will be canceled. (Up to 36 months of COBRA continuation coverage becomes available for health coverage only.) The only exception to this rule is a retiree/employee's dependent child who is born within nine months of the date of the retiree/employee's death can be added as long as the newborn is added to coverage as a dependent within 31 days of the date of birth.

Survivor coverage for enrolled children can continue until:

- The child reaches age 26 (unless incapacitated).
- Is no longer eligible according to the eligibility provisions for the health plans for reasons other than your – the retiree – death. Please see the **Eligibility** section for details on eligibility.
- Survivor coverage can continue if the child marries or enters into a new domestic partner relationship, but the new spouse or domestic partner or any other new dependents cannot be added to any Chevron health plan. If the child wants to add the new spouse or other new dependent to their Chevron health plan, survivor coverage ends, and up to 36 months of continuation coverage becomes available.

Survivor coverage will end early:

- If the survivor fails to timely pay any required premiums for coverage.
- 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 if you commit fraud or make an intentional misrepresentation of a material fact.

If your covered surviving spouse or covered child becomes ineligible for survivor coverage, the survivors can continue Chevron health 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 surviving 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.

# glossary

## After-Tax Contributions
After-tax contributions are withheld from your paycheck after federal and state income taxes are withheld.

## Ambulatory Surgical Center
A specialized facility established, equipped, operated and staffed primarily for performing surgical procedures and that meets one of the following two tests:

- It is licensed as an ambulatory surgical center by the appropriate local regulatory authority.
- Where licensing is not required, it meets all of the following requirements:
  - It is operated under the supervision of a licensed doctor (M.D. or D.O.), who is devoted full time to supervision, and it permits a surgical procedure to be performed only by a physician who has current privileges to perform the procedure in at least one area hospital.
  - Except for cases requiring only local infiltration of anesthetics, it requires that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist to administer the anesthetic. The anesthesiologist or anesthetist remains present throughout the surgical procedure.
  - It provides at least one operating room and at least one postanesthesia recovery room.
  - It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services.
  - It has access to a blood bank or blood supplies.
  - It has trained personnel and necessary equipment to handle emergency situations.
  - It provides the full-time services of registered nurses (R.N.s) for patient care in the operating rooms and in the postanesthesia recovery room.
  - It maintains an adequate medical record for each patient.
- An ambulatory surgical center can be a stand-alone facility or part of a hospital.

## Anthem Blue Cross (Anthem)
Anthem is the claims administrator for the Medical PPO in all states (except Hawaii where the plan is not available to employees). Anthem reviews, approves (or denies) and processes all claims other than those for outpatient prescription drugs, mental health and substance abuse services and vision care. Anthem also manages the network of providers. In addition, their staff informs plan members as to which charges are covered and which aren't under the plan. See the **Key Contacts** section at the front of this summary plan description for contact information for Anthem.

As part of your benefit, Anthem also offers a team of registered nurses — the Primary Nurse Team— dedicated solely to Chevron. You can call a Primary Nurse with questions or concerns for health matters big and small. A Primary Nurse can help you with condition management (for example diabetes or asthma), understanding an illness, an upcoming hospitalization, major surgery or treatment options. They can also help you understand and follow your physician's treatment plan and self-care suggestions, provide you with educational materials and individualized support, find physicians or other health care professionals in the network as well as connect you with communication resources. You can contact a nurse 24 hours a day, seven days a week at 1-844-627-1632.

Anthem's pre-service review team administers the plan's Clinical Review procedures. The Anthem staff reviews proposed hospitalization and other specified procedures to confirm they're medically necessary for the condition being treated. Approval is required before full plan benefits can be paid for some kinds of care. See the **Key Contacts** section at the front of this summary plan description for contact information for Anthem.

## Annual Deductible (Anthem)

The Medical PPO has a medical annual deductible. After you meet the deductible, coinsurance will apply. There are different deductible amounts for covered medical services depending on if you see a network or an out-of-network provider. Amounts paid for covered medical services provided by a network provider also count toward the out-of-network annual deductible. Amounts paid for covered medical services provided by an out-of-network provider also count toward the network annual deductible.

## Annual Deductible (Express Scripts)

The amount of covered prescription drug charges you pay for combined retail network and out-of-network services each calendar year before the plan begins paying its share of those charges.

## Before-Tax Contributions

Before-tax contributions are withheld from your pay first, before taxes are calculated and deducted, so you pay less in taxes. Before-tax contributions aren't subject to federal income taxes, and they aren't subject to state income taxes except in New Jersey and, for some certain benefits, Pennsylvania. Also (unlike before-tax contributions to 401(k) savings plans), before-tax contributions to health plans, the Health Care Spending Account (HCSA) and the Dependent Day Care Spending Account (DCSA) aren't subject to Social Security taxes.

## Before-Tax Contribution Plan

This is a plan that permits you to pay your portion of the monthly costs of any medical, dental, and vision plan coverage with before-tax contributions. If you choose before-tax deductions, you are automatically enrolled in the Before-Tax Contribution Plan. With this plan you are limited in your ability to make enrollment changes in your health plans during the year. Also, if you make contributions on a before-tax basis for medical coverage, you are required to make contributions on a before-tax basis for dental and vision coverage and vice versa.

## Billed Charges

Charges billed by a provider for covered services rendered to a Medical PPO Member or Dependent.

## Birthing Center

A facility that provides a home-like setting under a controlled environment for the purpose of childbirth. These facilities legally operate under the license of a qualified hospital.

## Blue Card Program

An Inter-Plan Arrangement under which the Host Blue Plan is responsible for contracting with and handling all interactions with its participating providers when members and dependents access covered services outside of the Medical PPO claims administrator's service area.

## Blue Cross Blue Shield Association (BCBSA)

An association of independent Blue Cross and Blue Shield companies, of which the claims administrator is a member.

## Blue Distinction Center of Transplants
A quality network of providers of transplant services nationwide. The Medical PPO covers certain organ and tissue transplants only if they are performed at a Blue Distinction Center of Transplants

## Brand-Name Drug
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.

## Care Management
A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet a member's or dependent's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

## Case Management
A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet a member's or dependent's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

## 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.

## Claims Administrator (Anthem)
Anthem is the medical claims administrator in all states (except Hawaii where the Medical PPO is not offered to employees). See the **Benefit Contact Information** chapter at the front of this summary plan description for contact information for Anthem.

## Claims Administrator (Express Scripts)
Express Scripts is the prescription drug claims administrator in all states (except Hawaii where the Medical PPO is not offered to employees). See the **Benefit Contact Information** chapter at the front of this summary plan description for contact information for Express Scripts.

## 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 Rates
The amount a participating provider agrees to accept as payment in full for covered services. Contracted rates are usually lower than the provider's normal charge.

## 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
The plans pay only for health services that are medically necessary and appropriate for the diagnosis and treatment of sickness or injury and for certain preventive care services. If you go to a network provider, plan benefits are based on the contracted rates that the provider charges. Benefits paid for these services, provided by out-of-network providers, are subject to the maximum allowable amount for the service or supply provided. You have to pay for services and supplies that aren't covered under the plan. And, if you go to an out-of-network provider, you must pay any charges in excess of the maximum allowable amount.

## Covered Services
A health care service or supply rendered to a Medical PPO member or Medical PPO dependent for which benefits are eligible for reimbursement pursuant to the terms of the Medical PPO, subject to any applicable deductible, co-payment, coinsurance or out-of-pocket maximums.

## 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.

Designated Virtual Network Provider

Refers to a provider or facility that has entered into an agreement with Anthem to deliver covered services via interactive audio and video modalities.

## Doctor (for purposes of the prescription drug program)
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.

## Domestic Partner
See the **Eligibility** chapter of this summary plan description for the definition of an eligible domestic partner.

## Domestic Partner's Dependent Child
See the **Eligibility** chapter of this summary plan description for the definition of an eligible domestic partner's dependent child.

## Domestic Partnership
See the **Eligibility** chapter of this summary plan description for the definition of a domestic partnership.

## Durable Medical Equipment
Durable medical equipment must meet all of the following requirements:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose.
- Is generally not useful to a person in the absence of sickness or injury.
- Is appropriate for use in the home.

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

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

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

## Eligible Spouse
See the **Eligibility** chapter of this summary plan description for the definition of an eligible spouse.

## Experimental or Investigational Service
A medical, surgical, diagnostic, psychiatric, mental health, substance abuse or other health care service, technology, supply, treatment, procedure, drug therapy or device that is determined by the claims administrator to be any of the following:

- Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- Subject to review and approval by any institutional review board for the proposed use or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The Medical PPO claims administrator, in its judgment, may deem an Experimental or Investigational Service covered under the Medical PPO for treating a life-threatening sickness or condition if the Medical PPO claims administrator determines that the Experimental Service:

- Is proved to be safe with promising efficacy; and
- Is provided in a clinically controlled research setting; and
- Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

For the purpose of this definition, the term "life-threatening" is used to describe sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.

## 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.

## Gender Identity Disorder
A disorder characterized by the following diagnostic criteria:

- A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
- Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
- The disturbance is not concurrent with a physical intersex condition.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The transsexual identity has been present persistently for at least two years.
- The disorder is not symptom of another mental disorder or chromosomal abnormality.

## Generic Drug
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 retiree health care benefits. For more information about HWES, see the **Company Contributions to Health Benefits supplement**.

## HIPAA
The Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

## Home Health Care Agency
A home health care agency provides services such as part-time or intermittent skilled nursing care, teaching and rehabilitation services. It also may provide rehabilitation equipment, based on a treatment plan prescribed by the patient's physician. The agency must be certified by Medicare and participate in the federal Medicare program in order for its charges to be covered under the plan.

## Hospice
Hospices offer an alternative to hospital care for treating terminally ill patients. Hospice is an integrated program of care administered in a home environment, hospital or hospice care facility that provides comfort and support services for the terminally ill when recommended by a physician and provided by a hospice agency that is licensed by the proper authorities of the state in which it provides services, and that is practicing within the scope of that license. Hospice care includes physical, social and spiritual care for the terminally ill person.

## 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 physicians, 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 physician.
  - Establishes a plan of treatment, for every patient that is reviewed, as needed by a physician 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.

## Host Blue Plan

A local Blue Cross and/or Blue Shield Licensee in a geographic area that is out of area from the claims cdministrator.

## 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 Care

Care that's provided while an individual is confined as a bed patient in a hospital.

## In-Network

A provider or facility that is providing care as a Network Provider.

## Inter-Plan Programs
The Blue Cross and Blue Shield Association Programs, including the Blue Card Program, where the Claims Administrator processes certain benefit claims for covered services received by Medical PPO members and Medical PPO dependents, which may include accessing the reimbursement arrangement of a provider that has contracted with another Blue Cross and/or Blue Shield Plan.

## 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.

## Live Health Online
Medical consultations by Medical PPO members or Medical PPO dependents with providers who contract with Live Health Online using the Internet via webcam, chat, or voice.

## Maintenance Medication
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.

## Maximum Allowable Amount
With respect to a Non-Network Provider (also called an out-of-network provider), a charge that is within a range of charges billed by physicians or other providers for the same service or supply, and does not exceed the amount normally charged by the non-network provider. Maximum Allowable Amounts may vary from one geographic area to another. In the case of covered charges for benefits for organ or tissue transplants the Claims Administrator may negotiate with non-network providers to provide certain organ transplantation services at a reduced rate (the "negotiated rate"); in which case "Maximum Allowable Amount" means the negotiated rate for such organ transplantation services.

In the case of covered charges for services, supplies, treatments or tests received from a provider who participates in the BlueCard Program, "Maximum Allowable Amount" means the lower of the billed covered charges for covered services or the negotiated price that the Host Blue makes available to the Claims Administrator for such services, supplies, treatments or tests.

The Medical PPO Claims Administrator, in its sole discretion, determines the Maximum Allowable Amount.

## 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

This term generally refers to health care services or supplies that are determined by the claims administrator, in its sole discretion, to be medically appropriate and that are all of the following:

- Necessary to meet the basic health needs of the plan member or covered dependent.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the health care service or supply.
- Consistent in type, frequency and duration with scientifically-based guidelines of national medical, research or health care coverage organizations or governmental agencies that are accepted by the claims administrator as to the type, frequency or duration of treatment.
- Consistent with the diagnosis of the condition.
- Required for reasons other than for the comfort or convenience of the patient, the patient's family, the physician or other provider.
- Demonstrated through prevailing peer-reviewed medical literature to be either of the following:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed.
  - Safe, with promising efficacy for treating a life-threatening sickness or condition, provided in a clinically controlled research setting and using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

For purposes of this definition, the term *life-threatening* is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment. The fact that a physician has performed, prescribed, ordered, recommended or approved a procedure or treatment, or the fact that it may be the only treatment for a particular illness, injury or pregnancy, doesn't mean that it's medically necessary and appropriate as defined here.

## Multi-Source Drug

A medication that is available from multiple manufacturers and can include Brand-Name Drugs and Generic Drugs depending on patent status.

## National PPO (Blue Card PPO) Network

The preferred provider organization network of physicians, hospitals and other healthcare providers maintained by the Medical PPO claims administrator to provide health care services at a contracted rate.

## National Preferred Formulary

A formulary is a list of drugs that are covered by your plan. It includes commonly prescribed medications that have been selected based on their clinical effectiveness, safety and opportunities for savings.

## Network Pharmacy
Express Scripts, the administrator of the Prescription Drug Program's retail pharmacy program, has negotiated a discount agreement with more than 60,000 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.

## Network Provider or In-Network
A physician, hospital or other health care provider who participates in the National PPO (Blue Card PPO) Network.

## Network Price
A discounted price charged for a prescription when a network pharmacy is used.

## Non-Network Provider or Out-of-Network
A physician, hospital or other health care provider who does not participate in the National PPO (Blue Card PPO) Network.

## Nonpreferred Brand-Name Drugs
Drugs that are covered by the Prescription Drug Program, which receive a lower level of reimbursement compared with preferred brand-name drugs. These drugs are not on Express Scripts' list of preferred brand-name drugs.

## Nurse
A registered nurse (R.N.), licensed vocational nurse (L.V.N.) or licensed practical nurse (L.P.N.).

## Nurse-Midwife
A registered nurse (R.N.) who has passed the American College of Nurse-Midwives' national exam for certification.

## 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
The out-of-pocket maximum is the most you will have to pay out-of-pocket for the year for covered services and supplies. When you reach this limit, the Medical PPO begins to pay 100 percent of the maximum allowable amounts for covered services and supplies. This amount is important because it protects you in the event you have a year with major health expenses. The Medical PPO has a combined out-of-pocket maximum for medical and mental health and substance abuse services, and another one for prescription drugs (both retail and mail-order). And there are different out-of-pocket maximums depending on if you see a network provider or an out-of-network provider. Amounts paid for covered services provided by a network provider also count toward the out-of-network maximum. Amounts paid for covered services provided by an out-of-network provider also count toward the network maximum.

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
Drugs that are dispensed by a retail or home delivery pharmacy (excluding drugs dispensed at hospitals, physicians' offices or skilled nursing facilities).

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

## 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)
A permanent service break may affect your health and welfare eligibility service which is used to determine your eligibility for retiree health benefits. For more information about permanent service breaks, see the **Company Contributions to Health Benefits supplement**.

## Physician (for purposes of the Medical PPO)
A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided. Physician shall also mean one of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, and is providing a service for which benefits are specified in the Medical PPO:

- A dentist (D.D.S. or D.M.D.)
- An optometrist (O.D.)
- A dispensing optician
- A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)

## Preferred Brand-Name Drugs
Drugs that are covered by the Prescription Drug Program and receive a higher level of reimbursement compared with nonpreferred drugs. The list of preferred brand-name drugs (sometimes called a formulary list) includes commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings. Preferred brand-name drugs receive a higher level of reimbursement compared with nonpreferred brand-name drugs. For updated formulary information, visit **www.Express-Scripts.com** or call Express Scripts Member Services.

## Prescription Drug Program ID Card
When you enroll in the Medical PPO, you'll receive a special 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.

## Preventive Care
The following preventive care services as required by the Patient Protection and Affordable Care Act, subject to reasonable medical management techniques based on the preventive care guidelines followed by the Medical PPO Claims Administrator and subject to all other provisions of this Medical PPO:

Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the Medical PPO Member or Medical PPO Dependent involved; and

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Medical PPO Member or Medical PPO Dependent involved; and

With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration to the extent not already included in certain recommendations of the USPSTF.

Preventive care benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per pregnancy in conjunction with childbirth. Benefits are only available if breast pumps are obtained from a DME provider or physician.

## Primary Care Provider
A family practice, general practitioner, pediatrician, internal medicine, ob/gyns, gyns, certified nurse midwife, nurse practitioner, physician assistant, and clinical/multi specialty group.

## Primary Nurse or Primary Nurse Team
A registered nurse who is dedicated to the member and their dependents and who performs case management or care management services.

## 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.

## Prosthetic Devices
Devices that replace a limb or body part. The device must be ordered or provided by or under the direction of a physician. Examples of prosthetic devices include:

- Artificial limbs.
- Artificial eyes.
- Breast prosthesis, as required by the Women’s Health and Cancer Rights Act of 1998.

## Provider
A hospital, medical or health care facility, physician, dentist or other health professional, licensed where required, performing within the scope of that license.

- A PPO (preferred provider organization), 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 non-PPO, nonparticipating or **out-of-network provider** does not have an agreement with the claims administrator pertaining to the payment of covered services for a member.

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

## Residential Treatment Program
A program of treatment given in a facility that provides 24-hour residential care to patients who don't require acute care services or 24-hour nursing care. The program provides structured mental health or substance abuse treatment that includes medical supervision by a physician and is staffed by a multidisciplinary team, which may include physicians, psychologists, social workers, registered nurses (R.N.s) and other health care professionals. The program must be 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.

## Skilled Nursing Facility
An institution that charges a fee and meets all of the following requirements:

- It furnishes room and board and nursing services for medical care.
- It has one or more licensed nurses on duty at all times, working under the constant supervision of a registered nurse (R.N.) or licensed physician.
- It has available, at all times, the services of a licensed physician.
- It complies with all legal requirements applicable to the operation of such an institution.
- It maintains medical records on all its patients at all times.
- It's approved under Medicare.

The term *skilled nursing facility* doesn't include any of the following:

- An institution used primarily as a rest facility.
- Facilities for the aged, drug addicts or alcoholics.
- Facilities provided primarily for custodial or educational care.

## Specialist
All professional providers who are not primary care providers.

## Specialty Drug
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.

## 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.

## Unproven Services

Health Services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from well-c**o**nducted randomized controlled trials or cohort studies in the prevailing published peer reviewed medical literature.

If you have a life-threatening sickness or condition (one that is more likely than not to cause death within one year of the date of the request for treatment), the claims administrator may, at its discretion, consider an otherwise Unproven Service to be a covered service for that sickness or condition. Prior to such a consideration, the claims administrator must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that sickness or condition.

## Utilization Management

The evaluation of the appropriateness and medical need for health care services, procedures and facilities according to evidence-based criteria or guidelines, and under the provisions of the plan to promote quality member outcomes, to optimize member benefits, and to promote effective use of resources.

# company contributions to health benefits

## supplement to the summary plan description (SPD) effective january 1, 2017

The **Company Contributions to Health Benefits Supplement** generally describes the Chevron Corporation Policy regarding its contribution to the cost of health benefits that are eligible for a Chevron company contribution. This is not a plan text, a summary plan description or a summary of material modification because the amount of the company contribution and how it is determined is not itself part of a health plan or the Retiree HRA Plan. Nevertheless, if it should be determined to be part of a health plan, the Supplement, as modified herein, shall constitute the applicable plan provision and summary plan description. There are no vested rights with respect to Chevron medical plans or any company contributions toward the cost of such medical plans. Rather, Chevron Corporation reserves all rights for any reason and at any time to amend, change or terminate these plans or to change or eliminate the company contribution toward the cost of such plans. Such amendments, changes, terminations or eliminations may be applicable without regard to whether someone previously terminated employment with Chevron or was previously subject to a grandfathering provision. Some benefit plans and policies described in the Supplement may be subject to collective bargaining and, therefore, may not apply to union-represented employees.

# table of contents

# benefit contact information

## Chevron Benefits HR2 Website

**Why access this website**

- Access summary plan descriptions (SPDs).
- Access benefit information and documents.
- Get other benefit phone numbers and websites that may not be referenced in this summary plan description.

**Website information**

- You don't need a password to access the information posted on this website.
- Active Employees: **hr2.chevron.com**
- Retirees: **hr2.chevron.com/retiree**

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

**Why contact this administrator**

- For questions about the amount of your company contribution to health benefits.

**Phone information**

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

**Website information**

- **Benefits Connection** website for personal information and conduct certain transactions.
- Active Employees: Go to **hr2.chevron.com** and click the **Benefits Connection** link from the top banner.
- Retirees: Go to **hr2.chevron.com/retiree** and click the **Benefits Connection** link from the top banner.

## Towers Watson OneExchange (OneExchange)

**Why contact this administrator**

- For questions about how the Chevron Corporation Post-65 Retiree Health Reimbursement Arrangement Plan (Retiree HRA Plan) works, how the account is funded, and how to submit a claim for reimbursement.

**Phone information**

- 1-844-266-1392 (Inside the U.S.)
- 1-801-994-9805 (Outside the U.S.)
- 5 a.m. - 6 p.m. Pacific time (7 a.m. - 8 p.m. Central time)

**Website information**

- Go to **hr2.chevron.com/retiree** and click the **OneExchange** link from the top banner.
- You can also go directly to **https://medicare.oneexchange.com/chevron**.
- On this website you can manage your Retiree HRA Plan account and reimbursement claims and also access individual health coverage information and decision-making support tools.

## Summary Plan Descriptions

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

- **For active employee health benefits**, go to **hr2.chevron.com** and click the **Your Benefits** tab for a complete listing of SPDs available for each plan.
- **For pre-65 retiree health benefits**, see the **Chevron Pre-65 Retiree Health Benefits** summary plan description on **hr2.chevron.com/retiree**.
- **For post-65 retiree health benefits**, see the **Chevron Post-65 Retiree Health Benefits** summary plan description on **hr2.chevron.com/retiree**.
- You can also call the HR Service Center to request that a copy be mailed to you, free of charge.

# contributions to employee medical coverage

Chevron Corporation determines the total cost of the various medical plans it offers. In general, Chevron Corporation has an 80/20 cost-sharing approach with respect to such total cost. With this approach, Chevron typically pays **80 percent** of the premium for your health care plan or a set **maximum company contribution**, whichever is less. You pay the remaining amount.

- The **maximum company contribution** is based on 80 percent of the current total premium of the Medical PPO Plan.
- If your plan's total premium costs *less* than the maximum company contribution, Chevron will generally pay 80 percent of the cost of your plan.
- If your plan's total premium costs *more* than the maximum company contribution, Chevron will pay up to the current maximum company contribution.

## Calculation Examples
## Company Contribution to Employee Medical Coverage

Important: All amounts displayed in this example are based on rates for the 2017 Plan Year. These rates are subject to change each year.

**Maximum Company Contribution – Sample Calculation**
January 1 through December 31, 2017
Sample calculation for *You + Family* coverage level

- Medical PPO Plan (You + Family) Total Premium = $1,749
- $1,749 x 80% = $1,400
- **2017 Maximum Company Contribution for You + Family Coverage is $1,400**

**The maximum company contribution for all coverage levels for the 2017 Plan Year are:**

| Coverage Level | Maximum Monthly Company Contribution |
|---|---|
| You Only | $518 |
| You + One Adult | $1,036 |
| You + Child(ren) | $881 |
| You + Family | $1,400 |

| Plan Name | Monthly Cost You + Family Coverage* | | | Company Contribution Percentage |
|---|---|---|---|---|
| | Total Premium | Company Contribution | Employee Contribution** | |
| **Medical PPO Plan** | **$1,749** | **$1,400** | **$344** | **80%** |
| High Deductible Health Plan[1] | $1,478 | $1,400 | $74 | 95% |
| High Deductible Health Plan Basic[1] | $1,428 | $1,400 | $23 | 98% |
| Global Choice Plan[2] (U.S.-Payroll Expatriates) | $1,260 | $1,008 | $247 | 80% |

**These rates do not include the tobacco surcharge, if applicable.*

***The employee contribution in the table above is actually slightly less than 20% due to actuarial projections used to estimate the annual total premium.*

*[1] The total premium for this plan is **greater** than the maximum company contribution ($1,400) so the company contribution is $1,400.*

*[2] The total premium for this plan is **less** than the maximum company contribution ($1,400) so the company contribution is 80% of the total premium for this plan ($1,260 x 80%).*

# contributions to pre-65 retiree health benefits

The information in this section assumes you are a Chevron retiree and you're eligible for both Chevron pre-65 retiree health benefits and the company contribution to retiree health benefits. See the **Chevron Pre-65 Retiree Health Benefits** summary plan description on **hr2.chevron.com/retiree** for eligibility information.

## Pre-65 Retiree Medical

If you're a pre-65 eligible retiree, the company currently continues to share the cost of your medical coverage. For pre-65 eligible retirees, the company contribution is automatically factored into your monthly medical premium for your Chevron pre-65 retiree group medical coverage. Chevron Corporation reserves all rights for any reason and at any time to amend, change or terminate the medical plans or to change or eliminate the company contribution toward the cost of such medical plans. If you're a pre-65 eligible retiree, your company contribution to pre-65 retiree group medical coverage is currently determined as follows:

### Pre-65 Company Contribution Formula

| | |
|---|---|
| **$** | Your **starting company contribution amount** is based on the maximum company contribution amount for *active* employees for the applicable plan and coverage level in the calendar year in which you retire. See the **Contributions to Employee Medical Coverage** section in this supplement for information about how the maximum company contribution amount for active employees is calculated.* |
| **times %** | Your starting company contribution amount is then **prorated** based on the applicable percentage that corresponds to your points at retirement. See the **Proration of Starting Company Contribution Amount** chapter later in this supplement for additional details. *Please note that the total premium cost of retiree group medical coverage is usually greater than the maximum company contribution, so even if you have enough points to receive 100 percent of the starting company contribution, you will still have to pay for your pre-65 retiree group medical coverage.* |
| **equals $** | Your **final company contribution amount** to pre-65 retiree group medical coverage generally doesn't change until you turn age 65, *unless* your coverage level changes during a subsequent open enrollment or as a result of a qualifying life event. Your contribution amount will be recalculated based on the new coverage level in this situation. |

**Chevron limits future increases to the applicable pre-65 company contribution to no more than 4 percent each year, applied to the starting company contribution amount.*

The company contribution for post-65 participants is different. See the **Contributions to Post-65 Retiree Health Benefits** section in this supplement for more information.

**Example Calculation for Company Contribution to Pre-65 Retiree Group Medical Coverage**

*Important: This is an example only. All amounts displayed in this example are based on rates for the 2017 Plan Year. These rates are subject to change each year.*

**$1,400**

**Starting company contribution** amount is based on the maximum company contribution amount for *active* employees for the applicable plan and coverage level in the calendar year in which you retire. Example employee retires in 2017 with:

- High Deductible Health Plan (HDHP).
- You + Family coverage.
- Maximum company contribution for active employee coverage for You + Family coverage in the HDHP in 2017 is $1,400.

**times 95%**

Your starting company contribution amount is then **prorated** based on the applicable percentage that corresponds to your points at retirement. Example employee is eligible for the 80-point scale and retires in 2017 with:

- 78 points at retirement.
- Proration is 95% of the starting company contribution amount.

**equals $1,330** per month

Your **final company contribution amount** to pre-65 retiree group medical coverage generally doesn't change until you turn age 65, *unless* your coverage level changes during a subsequent open enrollment or as a result of a qualifying life event. Your contribution amount will be recalculated based on the new coverage level in this situation.

### Mixed pre-65 and post-65 families

Effective January 1, 2017, if you have a combination of pre-65 and post-65 eligible participants in your family, the company contribution is calculated and applied according to age. For pre-65 participants, the contribution is calculated as described in this section and applied to your monthly premium for pre-65 retiree group medical coverage. For post-65 participants, the contribution is calculated as described in the **Contributions to Post-65 Retiree Health Benefits** section in this supplement and applied to the Retiree HRA Plan account for each eligible post-65 participant. For this reason, your 2017 benefit statements from the HR Service Center may display a different amount than in previous years if you have both pre-65 and post-65 participants in your family.

### Medicare eligible due to disability

The company contribution amount toward pre-65 retiree group medical coverage is different if you are Medicare-eligible due to disability. Contact the HR Service Center for more information if these situations apply to you.

### If you are rehired

If you're a pre-65 eligible retiree and are subsequently rehired, when you retire again, your company contribution to pre-65 retiree group medical coverage is currently determined as follows:

- Your **starting company contribution amount** continues to be based on the maximum company contribution amount for active employees for the applicable plan and coverage level in the calendar year in which you first terminated/retired.

- Your starting company contribution amount is then **prorated** based on the applicable percentage that corresponds to your points. You are eligible for the better of:
  - The percentage that corresponds to your points based on the date your *first* terminated/retired.
  - The percentage that corresponds to your points based on the date of your *second* termination/retirement.

  See the **Proration of Starting Company Contribution Amount** chapter later in this supplement for additional details. *Please note that the total premium cost of retiree group medical coverage is usually greater than the maximum company contribution, so even if you have enough points to receive 100 percent of the starting company contribution, you will still have to pay for your pre-65 retiree group medical coverage.*

- Your **final company contribution amount** to pre-65 retiree group medical coverage generally doesn't change until you turn age 65, *unless* your coverage level changes during a subsequent open enrollment or as a result of a qualifying life event. Your contribution amount will be recalculated based on the new coverage level in this situation.

## Pre-65 Retiree Dental

If you're eligible for pre-65 retiree group dental coverage, the company currently continues to share the cost of your dental coverage. If you're eligible for pre-65 retiree group dental coverage and the company contribution, the contribution to retiree group dental coverage is based on a fixed dollar amount for each coverage tier. You pay the difference between the company's contribution and the total premium cost. Chevron Corporation reserves all rights for any reason and at any time to amend, change or terminate the dental plans or to change or eliminate the company contribution toward the cost of such dental plans.

## Pre-65 Mental Health and Substance Abuse

The company currently contributes 100 percent of the total cost for Mental Health and Substance Abuse (MHSA) Plan premiums for pre-65 eligible retirees and pre-65 eligible dependents. You do not pay a premium for the MHSA Plan. (As a reminder, retirees and covered dependents are not eligible for the MHSA Plan if they are eligible for Medicare.) Chevron Corporation reserves all rights for any reason and at any time to amend, change or terminate the MHSA Plan or to change or eliminate the company contribution to the MHSA Plan.

## Pre-65 Retiree Medical Coverage Example Scenarios

Here are some examples to help you understand how points and company contribution amounts are currently determined. These examples assume that the individuals are eligible for pre-65 retiree group medical coverage, the company contribution to retiree medical coverage, and met all enrollment milestone requirements. **They are estimates in which the age, Health and Welfare Eligibility Service ("service"), and points are rounded for purposes of the illustration only.** Actual age plus years of service point calculations performed by the HR Service Center upon an employee's retirement extend to four decimal points, and service is currently counted until the end of the month in which the employee terminates Chevron employment. See the **Proration of Starting Company Contribution Amount** chapter in this supplement for point scale tables and information.

### Chris, a Chevron employee leaving under the 90-point scale

Chris is 36 years old with seven years of service when he leaves Chevron.
Chris is eligible for the 90-point scale.

#### Chris' points

Chris has 43 age plus years of service points (36 years old plus seven years of service). However, Chris is not eligible for retiree health benefits because he doesn't meet the eligibility requirement of 50 years old with 10 years of service.

If Chris doesn't leave Chevron until he turns age 50, Chris would have 71 age plus years of service points (50 years old plus 21 years of service). This means he would be eligible for a 61 percent proration of the starting company contribution for retiree medical coverage.

#### Chris' eligibility for the 100 percent of the starting company contribution

To be eligible for 100 percent of the starting company contribution to retiree medical coverage, Chris would have to remain an eligible employee until he has 90 age plus years of service points.

### Pat, a Chevron employee grandfathered under the 80-point scale

Pat is grandfathered under the grandfathering provision — age 50 or older with 10 years of service on December 31, 2004. Pat is 56 years old with 16 years of service when she leaves Chevron.

#### Pat's points

Pat has 72 age plus years of service points (56 years old plus 16 years of service). This means she would be eligible for 80 percent proration of the starting company contribution for retiree medical coverage.

#### Pat's eligibility for the 100 percent of the starting company contribution

To be eligible for 100 percent of the starting company contribution to retiree medical coverage, Pat would have to remain an eligible employee until she has 80 age plus years of service points.

*See the **Proration of Starting Company Contribution Amount** chapter in this supplement for information about grandfather rules and provisions.*

### Robert, a former Chevron employee

Robert is a former Chevron employee, grandfathered under former Chevron rules. Robert is 58 years old with 28 years of service when he retires.

#### Robert's points

Robert has 86 age plus years of service points (58 years old plus 28 years of service). Robert is grandfathered under the former Chevron rule because he had at least 20 years of continuous service or 65 points on June 30, 2002, and when he retires he has at least 25 years of health and welfare eligibility service or at least 75 points.

#### Robert's eligibility for 100 percent of the starting company contribution

Because he is eligible for the grandfather rule, Robert is eligible for 100 percent of the starting company contribution to retiree medical coverage.

*See the **Proration of Starting Company Contribution Amount** chapter in this supplement for information about grandfather rules and provisions.*

### Maria, a former Texaco employee

Maria is a former Texaco employee, grandfathered under the former Texaco rules, because she was age 45 or older on October 1, 1999. Maria is 60 years old with 16 years of service when she leaves Chevron.

#### Maria's points

Maria has 76 age plus years of service points (60 years old plus 16 years of service). Maria is grandfathered under the former Texaco rule because she was age 45 or older as of October 1, 1999, and is retiring at age 55 or older with 10 years of health and welfare eligibility service.

#### Maria's eligibility for 100 percent of the starting company contribution

Because she is eligible for the grandfather rule, Maria is eligible for 100 percent of the starting company contribution to retiree medical coverage.

*See the **Proration of Starting Company Contribution Amount** chapter in this supplement for information about grandfather rules and provisions.*

## Terry, a former Unocal employee

Terry is a former Unocal employee.
Terry is 59 years old with 26 years of service when he leaves Chevron.
Terry is eligible for the Chevron 90-point scale.

### Terry's points

Terry has 85 age plus years of service points (59 years old plus 26 years of service).

- Terry is eligible for 85 percent proration of the starting company contribution for retiree medical coverage under the Chevron 90-point scale.
- Terry is grandfathered under the former Unocal rule because he is retiring after July 1, 2006 at age 55 or older with 10 or more years of service, and he has 20 or more years of service after age 35 as of December 31, 2007. This means he would be eligible for 100 percent of the starting company contribution for retiree medical coverage under the Unocal transition scale.
- Under the Unocal grandfather rule, Terry is eligible for the *greater* starting company contribution proration percentage from the Chevron 90-point scale (85%) or from the grandfathered Unocal transition scale (100%). Therefore, Terry is eligible for **100 percent** of the starting company contribution for retiree medical coverage.

### Terry's eligibility for 100 percent of the starting company contribution

Because he is eligible for the Unocal grandfather rule and the Unocal transition scale company contribution proration percentage is greater, Terry is eligible for 100 percent of the starting company contribution to retiree medical coverage.

*See the **Proration of Starting Company Contribution Amount** chapter in this supplement for information about grandfather rules and provisions.*

## Mike, a former Unocal employee

Mike is a former Unocal employee.

As of December 31, 2007, Mike was age 54 with 20 years of service. For this reason, Mike is not eligible for the Unocal grandfather rule because he did not satisfy the age requirement (at least age 55 with 10 or more years of health and welfare eligibility service) as of December 31, 2007. Therefore, when he retires, Mike will be eligible for the Chevron 90-point scale.

### Mike's eligibility for 100 percent of the starting company contribution

Mike will be eligible for 100 percent of the starting company contribution to retiree medical coverage if he remains an eligible employee until he earns 90 age plus years of service points.

*See the **Proration of Starting Company Contribution Amount** chapter in this supplement for information about grandfather rules and provisions.*

# contributions to post-65 retiree health benefits

The information in this section assumes you, the retiree, are eligible for both Chevron post-65 retiree health benefits and the company contribution to retiree health benefits. See the **Chevron Post-65 Retiree Health Benefits** summary plan description on **hr2.chevron.com/retiree** for eligibility information.

## Post-65 Retiree Medical

If you're a post-65 eligible retiree and eligible for Medicare, the company currently continues to share the cost of your medical coverage. Post-65 eligible retirees and/or their post-65 eligible dependents will receive the company contribution through a health reimbursement arrangement (HRA). The Chevron Corporation Post-65 Retiree Health Reimbursement Arrangement Plan **– Retiree HRA Plan –** is the health reimbursement arrangement that Chevron sponsors for post-65 eligible retirees and their post-65 eligible dependents to receive their company contributions to retiree health coverage. This is a *reimbursement* account. This means you'll pay premiums for coverage directly to your insurance carriers and submit claims to OneExchange for reimbursement from your HRA. Chevron Corporation reserves all rights for any reason and at any time to amend, change or terminate the Retiree HRA Plan or to change or eliminate the company contribution to the Retiree HRA Plan. If you're a post-65 eligible retiree, your company contribution to post-65 retiree individual medical coverage is currently determined as follows:

### Post-65 Company Contribution Formula

| | |
|---|---|
| **$** | All post-65 eligible retirees receive the same **starting company contribution amount**, regardless of your year of retirement.* |
| **times %** | Your starting company contribution amount is then **prorated** based on the applicable percentage that corresponds to your points at retirement. See the **Proration of Starting Company Contribution Amount** section later in this supplement for additional details. |
| **minus $** | Minus an allocation to the Chevron Supplemental Catastrophic Prescription Drug Benefit. This is a flat rate for all eligible participants. |
| **equals $** | Your **final company contribution** to the health reimbursement arrangement (HRA) for post-65 eligible participants.** |

**There may be a different amount for certain legacy company retirees or other grandfathered groups.*

*** Chevron's contribution for post-65 participants who are eligible for retiree dental coverage with a company contribution may be added to this amount. See the Post-65 Retiree Dental heading later in this section for more information.*

If you and your post-65 eligible dependent are eligible for the HRA, you and your dependent will each have a separate HRA account based on the HRA of the eligible retiree. See the **Chevron Corporation Post-65 Retiree Health Reimbursement Arrangement Plan** *chapter of the summary plan descrip*tion for more information about the Retiree HRA Plan, including important eligibility and enrollment rules.

The company contribution for pre-65 participants is different. See the **Contributions to Pre-65 Retiree Health Benefits** section in this supplement for more information.

**Example Calculation for Company Contribution to Post 65 Retiree HRA Contribution for 2017**

*This is an example only. All amounts displayed are effective for the 2017 Plan Year and may be subject to change in the future. Your numbers may be different based on your situation.*

| | |
|---|---|
| **$96.20*** | All post-65 eligible retirees receive the same **starting company contribution amount**, regardless of your year of retirement.* |
| **times 100%** | Your starting company contribution amount is then **prorated** based on the applicable percentage that corresponds to your points at retirement. Example employee is eligible for 100% of the starting company contribution. |
| **minus $6.28** | Minus an allocation to the Chevron Supplemental Catastrophic Prescription Drug Benefit. This is a flat rate for all eligible participants. |
| **equals $89.92**** per month | Your **final company contribution** to the health reimbursement arrangement (HRA) for post-65 eligible participants. This example retiree medical amount would be applied to the HRA each month for this sample retiree and all post-65 eligible dependents in the family. |

**There may be a different amount for certain legacy company retirees or other grandfathered groups.*

*** Chevron's contribution for post-65 eligible who are eligible for retiree dental coverage with a company contribution may be added to this amount. See the Post-65 Retiree Dental heading later in this section for more information.*

### Mixed pre-65 and post-65 families

Effective January 1, 2017, if you have a combination of pre-65 and post-65 eligible participants in your family, the company contribution is calculated and applied according to age. For pre-65 participants, the contribution is calculated as described in the **Contributions to Pre-65 Retiree Health Benefits** section in this supplement and applied to your monthly premium for pre-65 retiree group medical coverage. For post-65 participants, the contribution is calculated as described in this section and applied to the Retiree HRA Plan account for each eligible post-65 participant.

### If you are rehired

If you're a post-65 eligible retiree and are subsequently rehired, when you retire again, your company contribution to post-65 retiree individual health coverage is currently determined as follows:

- All post-65 eligible retirees receive the same **starting company contribution amount**, regardless of your year of retirement or if you were rehired.*
- Your starting company contribution is then **prorated** based on the applicable percentage that corresponds to your points. You are eligible for the better of:
  - The percentage that corresponds to your points based on the date you *first* terminated/retired.
  - The percentage that corresponds to your points based on the date of your *second* termination/retirement.

  See the **Proration of Starting Company Contribution Amount** chapter later in this supplement for additional details.

** There may be a different amount for certain legacy company retirees or other grandfathered groups.*

## Post-65 Retiree Dental

If you're eligible for dental coverage and a company contribution to retiree dental coverage, the company's contribution to retiree dental coverage is currently a fixed dollar amount. Post-65 eligible retirees and/or their post-65 eligible dependents will receive the dental company contribution through the Chevron Corporation Post-65 Retiree Health Reimbursement Arrangement Plan **– Retiree HRA Plan.** The Retiree HRA Plan is the health reimbursement arrangement that Chevron sponsors for post-65 eligible retirees and their post-65 eligible dependents to receive their company contributions to retiree health coverage. This is a *reimbursement* account. This means you'll pay premiums for coverage directly to your insurance carriers and submit claims to OneExchange for reimbursement from your HRA. Please see the **Chevron Corporation Post-65 Retiree Health Reimbursement Arrangement Plan** chapter of the summary plan description for important eligibility and enrollment rules. Chevron Corporation reserves all rights for any reason and at any time to amend, change or terminate the Retiree HRA Plan or to change or eliminate the dental company contribution to Retiree HRA Plan.

# Post-65 Retiree Medical Coverage Example Scenarios

Here are some examples to help you understand how points and company contribution amounts are currently determined. These examples assume that the individuals are eligible for post-65 retiree individual medical coverage, are eligible for the company contribution to the Retiree HRA Plan, and met all enrollment milestone requirements. **They are estimates in which the age, Health and Welfare Eligibility Service ("service"), and points are rounded for purposes of the example only.** Actual age plus years of service point calculations performed by the HR Service Center upon an employee's retirement extend to four decimal points, and service is currently counted until the end of the month in which the employee terminates Chevron employment. See the **Proration of Starting Company Contribution Amount** chapter in this supplement for point scale tables and information.

### Chris, a Chevron employee leaving under the 90-point scale

Chris is 66 years old with 23 years of service when he leaves Chevron.
Chris is eligible for the 90-point scale.

### Chris' points

Chris has 89 age plus years of service points (66 years old plus 23 years of service). This means he would be eligible for a 97 percent proration of the starting company contribution to retiree medical coverage. If Chris is eligible for the Retiree HRA Plan and meets the enrollment requirements when he retires, the final company contribution amount will be applied to his Retiree HRA Plan account.

### Chris' eligibility for the 100 percent of the starting company contribution

To be eligible for 100 percent of the starting company contribution to retiree medical coverage, Chris would have to remain an eligible employee until he has 90 age plus years of service points.

### Pat, a Chevron employee grandfathered under the 80-point scale

Pat is grandfathered under the grandfathering provision — age 50 or older with 10 years of service on December 31, 2004. Pat is 67 years old with 16 years of service when she leaves Chevron.

### Pat's points

Pat has 83 age plus years of service points (67 years old plus 16 years of service). This means she is eligible for 100 percent of the starting company contribution to retiree medical coverage. If Pat is eligible for the Retiree HRA Plan and meets the enrollment requirements when she retires, her final company contribution amount will be applied to her Retiree HRA Plan account.

### Pat's dependent eligibility for the company contribution

Pat's spouse, Casey, is 68 years old and never worked at Chevron or a legacy company. As long as Casey remains Pat's eligible dependent and both meet all the eligibility and enrollment requirements when Pat retires, both Pat and Casey would receive the same final company contribution amount in their own separate Retiree HRA Plan accounts.

*See the **Proration of Starting Company Contribution Amount** chapter in this supplement for information about grandfather rules and provisions.*

### Terry, a post-65 retiree with pre-65 dependents

Terry is currently 67 years old.

Terry retired from Chevron with over 90 age plus years of service points. This means Terry is eligible for 100 percent of the starting company contribution amount to retiree medical coverage. Terry met all eligibility and enrollment requirements and her final company contribution amount is currently being applied to her Retiree HRA Plan account.

Terry's spouse, Drew, is 55 years old. Terry's step-son, Jason, is 25 years old. Drew and Jason are covered as Terry's dependents in pre-65 retiree group medical coverage because both are under age 65. The company contributes to Drew and Terry's group medical coverage through a premium reduction each month.

See the **Contributions to Pre-65 Retiree Health Benefits** section in this supplement for more information about those company contributions.

## Maria and John, a post-65 Chevron couple

Maria is 66 years old and still working at Chevron. John retired from Chevron 9 years ago. Maria currently covers John as a dependent on her Chevron employee group health coverage.

- John is 69 years old and retired from Chevron with over 90 points; therefore, John is eligible for 100 percent of the starting company contribution amount to retiree medical coverage. As long as John meets the enrollment requirements, he's eligible to receive his final company contribution amount to his own Retiree HRA Plan account when he enrolls in post-65 Chevron retiree medical coverage.
- Maria will have 87 points when she retires next year; she will be eligible for a 91 percent proration of the starting company contribution amount to retiree medical coverage. As long as Maria meets the enrollment requirements, she's eligible to receive her final company contribution amount to her own Retiree HRA Plan account when she retires and enrolls in post-65 Chevron retiree medical coverage.

Maria's retirement from Chevron will trigger an enrollment milestone for *both* Maria and John.

- For Maria, the enrollment milestone is *retirement from Chevron*.
- For John, the enrollment milestone is *losing employer group health coverage*.

Because they are a Chevron couple, John and Maria need to keep the following Chevron couples rule in mind regarding their company contribution: *If you and your spouse are both post−65 Chevron eligible retirees, each separate HRA account will be based on whether you are listed as a dependent or the primary retiree when you enroll in post-65 individual medical coverage with OneExchange.*

John and Maria's choices are:

- John can become the primary retiree and Maria the dependent. Both John and Maria would receive John's final company contribution amount (based on 100 percent of the starting company contribution) to their own separate Retiree HRA Plan accounts.
- Maria can become the primary retiree and John the dependent. Both John and Maria would receive Maria's final company contribution amount (based on 91 percent proration of the starting company contribution) to their own separate Retiree HRA Plan accounts.
- John and Maria can each enroll as individual participants since they are both former eligible employees who qualify as eligible retirees. In this scenario, John would receive his final company contribution amount (based on 100 percent of the starting company contribution) to his Retiree HRA Plan account. Maria would receive her final company contribution amount (based on 91 percent proration of the starting company contribution) to her Retiree HRA Plan account.

# proration of starting company contribution amount

Your applicable starting company contribution amount may be prorated based upon your **points** at retirement. Points represent the sum of your **age** plus **years of health and welfare eligibility service ("service")** when you leave the company. Each point level corresponds to a percentage, which represents the percentage of the starting company contribution for which you are eligible. In general, the longer you work, the more points you can accumulate, resulting in a higher percentage and, therefore, a higher company contribution amount toward retiree medical coverage.

In general, if you retired on or after July 1, 2002, one of the following point scales is used to determine the amount of company contribution you receive:

- The **90-point scale** applies to retirees eligible for retiree medical who terminate or retire on or after January 1, 2005, unless a grandfather rule applies to you.

- The **80-point scale** applies to retirees eligible for retiree medical who retired between July 1, 2002 and December 31, 2004, and to employees who were age 50 or over with at least 10 years of service on December 31, 2004 (as determined under the applicable rules in effect on December 31, 2004), and who retire after that date, unless a grandfather rule applies to you.

The following chart indicates the company contribution under the 80-point scale and the 90-point scale:

| **Age** *plus* **Years of Health and Welfare Eligibility Service Points** | **Company Contribution under the:** | |
|---|---|---|
| | **80-Point Scale** | **90-Point Scale** |
| 60 | 50% | 50% |
| 61 | 52.5% | 51% |
| 62 | 55% | 52% |
| 63 | 57.5% | 53% |
| 64 | 60% | 54% |
| 65 | 62.5% | 55% |
| 66 | 65% | 56% |
| 67 | 67.5% | 57% |
| 68 | 70% | 58% |
| 69 | 72.5% | 59% |
| 70 | 75% | 60% |
| 71 | 77.5% | 61% |
| 72 | 80% | 62% |
| 73 | 82.5% | 63% |
| 74 | 85% | 64% |
| 75 | 87.5% | 65% |
| 76 | 90% | 67% |
| 77 | 92.5% | 69% |
| 78 | 95% | 71% |
| 79 | 97.5% | 73% |
| 80 | 100% | 75% |
| 81 | | 77% |
| 82 | | 79% |
| 83 | | 81% |
| 84 | | 83% |
| 85 | | 85% |
| 86 | | 88% |
| 87 | | 91% |
| 88 | | 94% |
| 89 | | 97% |
| 90 | | 100% |

## Grandfather Rules

There are some exceptions to the company contribution amount you may receive. Some retirees are eligible for retiree health care coverage at 100 percent of the maximum company contribution under the rules of former Chevron, former Texaco or former Unocal plans. In these cases, retirees have been protected, or grandfathered, under old or alternate rules. These grandfather rules are described below:

- A former Chevron employee is a person who otherwise qualifies as an eligible employee and who was employed by Chevron immediately prior to its merger with Texaco Inc. and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

- A former Texaco employee is a person who otherwise qualifies as an eligible employee and who was employed by Texaco Inc. immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

- A former Unocal employee is a person who otherwise qualifies as an eligible employee, who was employed by Unocal immediately prior to its merger with Chevron Corporation, and who has not been terminated and rehired by Chevron since the merger with Unocal.

- Whether an employee meets the conditions to have a grandfather rule (including the 80-point scale) apply is determined under the rules in place as of the time the grandfather rule became effective. For example, a change to the Health and Welfare Eligibility Service, effective January 1, 2012, does not affect the amount of service the employee had on December 31, 2004 for purposes of whether the 80-point scale applies. (However, if the 80-point scale applies to an employee without regard to the additional service, the additional service would count toward the employee's points on the 80-point scale).

**If you're a former Chevron, or former Caltex or former Texaco employee** and meet one of the following grandfathering requirements, you receive 100 percent of the company's contribution toward your medical coverage when you retire, subject to the 4 percent limit on future increases to the company contribution for pre-65 eligible retirees:

- You're a former Chevron or former Caltex employee employed by the company on June 30, 2002, and you meet all of the following criteria:

    - You must have had at least 20 years of continuous service or 65 points (age plus years of continuous service) on June 30, 2002, (as determined under the applicable rules in effect on June 30, 2002).

    - You have at least 25 years of health and welfare eligibility service or at least 75 points (age plus years of health and welfare eligibility service) when you retire.

    - You have not been rehired since July 1, 2002.

- You're a former Texaco employee employed by the company on June 30, 2002, and on October 1, 1999, you were a Texaco employee who was age 45 or older and you retire at age 55 or older with at least 10 years of health and welfare eligibility service.

**If you're a former Unocal employee** employed by the company on June 30, 2006, you may be eligible for a company contribution percentage based on the grandfathered Unocal transition scale. If you retire on or after July 1, 2006, at age 55 or older with 10 or more years of health and welfare eligibility service, and you meet the age and service requirements by December 31, 2007, (as determined under the applicable rules in effect on December 31, 2007), you will be eligible for the *greater* (that is, the greater company contribution percentage) of the Chevron 90-point scale or the grandfathered Unocal transition scale shown below:

## Grandfathered Unocal Transition Scale

| Years of Service After Age 35 | Company Contribution Percentage |
|---|---|
| **10** | 50.0% |
| **11** | 55.0% |
| **12** | 60.0% |
| **13** | 65.0% |
| **14** | 70.0% |
| **15** | 75.0% |
| **16** | 80.0% |
| **17** | 85.0% |
| **18** | 90.0% |
| **19** | 95.0% |
| **20** | 100.0% |

# about health and welfare eligibility service

## Definition of Health and Welfare Eligibility Service

Your health and welfare eligibility service is used to determine your eligibility for vacation, service awards, Short-Term and Long-Term Disability plans and retiree health care benefits. The following applies to an individual who is an employee on or after January 1, 2012. Different rules apply to an individual who terminated employment prior to January 1, 2012.

Health and welfare eligibility service is generally the period of time you're employed by Chevron or by any other member of the Chevron affiliated group, and may include periods when you're not an eligible employee for U.S. pay and benefits.

Health and welfare eligibility service includes all the time you are on an approved Disability Leave for which you are receiving benefits under the Chevron Long-Term Disability Plan. Under special rules, it may also include the time you are on certain other approved leaves of absence. Special rules apply if you do not timely return to active work with a participating company or if you terminate your employment while on an approved leave of absence. Health and welfare eligibility service may also include the time you have been providing services as a “leased employee” on or after July 1, 2002 to a member of the Chevron affiliated group (at the time the services are performed) and you become an employee after providing service as a leased employee, as determined by Chevron Corporation in its sole discretion. If you believe one of these special rules apply to you, contact the HR Service Center for further information.

If you leave Chevron after July 1, 2002, and are rehired within 365 days, your service will include the time you were away. If you’re gone longer than 365 days and you haven’t had a permanent service break as a result of your absence, your service before you left will be added to your service after you’re rehired.

If you left Chevron and were rehired, your service before you left will be added to your service after you’re rehired unless you incurred a Permanent Service Break. If you have service with an acquired company prior to the date of the acquisition of that company by Chevron, special rules may apply — contact the HR Service Center for more information.

Note on grandfathering rules: The definition of health and welfare eligibility service has changed over time, and sometimes it has changed to include additional service that was not previously included. This will not change whether you are subject to a grandfather rule in effect prior to the change. This is because whether an employee meets the conditions to have a grandfather rule apply is determined under the rules in place as of the time the grandfather rule was effective.

## Definition of a Permanent Service Break

You will not have a permanent service break if you leave Chevron with more than five years of health and welfare eligibility service. You will, however, have a permanent service break if you leave Chevron before you have five years of health and welfare eligibility service and you’re not rehired within five years. If you left employment with Chevron before January 1, 2012, the applicable rules at the time of your termination will apply to whether you had a permanent service break.

# glossary

## Former Atlas Employee
A person who otherwise qualifies as an eligible employee and who was employed by Atlas immediately prior to its merger with Chevron Corporation (or was employed by Chevron Northeast Upstream Corporation after the merger and on or before October 1, 2011) and who has not been terminated and rehired by Chevron or its affiliates.

## Former Caltex Employee
A person who otherwise qualifies as an eligible employee and who was employed by Caltex immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron or its affiliates.

## Former Chevron Employee
A person who otherwise qualifies as an eligible employee and who was employed by Chevron immediately prior to its merger with Texaco Inc. and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

## Former Texaco Employee
A person who otherwise qualifies as an eligible employee and who was employed by Texaco Inc. immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron since the merger with Texaco Inc.

## Former Unocal Employee
A person who otherwise qualifies as an eligible employee and who was employed by Unocal immediately prior to its merger with Chevron Corporation and who has not been terminated and rehired by Chevron since the merger with Unocal.