wellness programs

summary plan description

effective january 1, 2020

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This document describes the Wellness Programs as of January 1, 2020 that Chevron sponsors for eligible employees. This information constitutes the SPD of the Chevron Wellness programs as required by the Employee Retirement Income Security Act of 1974 (ERISA). These descriptions don't cover every provision of the program. 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**.

Non-U.S.-payroll expatriates working in the United States should refer to the **Health Benefits for Expatriates in the U.S.** summary plan description available at **hr2.chevron.com** for information about the wellness programs that may apply to you.

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. Once approved, plan changes are incorporated into the plan texts, SPDs and vendor administration at the effective date.

Chevron Corporation is the plan administrator of the plans described in this booklet. Chevron Corporation, in its sole discretion, has the authority to interpret these plans, and it may adopt rules and procedures to implement any plan provision. Chevron Corporation also has the authority to take any appropriate action to administer these plans. Subject to the plans' review procedures, Chevron Corporation's decisions about these plans are conclusive and binding on all persons.

Some benefit plans and policies described in this document may be subject to collective bargaining and, therefore, may not apply to union-represented employees.

update to health rewards

update to the summary plan description

effective january 1, 2022

All changes described in this SMM are effective January 1, 2022 unless otherwise indicated.

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

health rewards chapter

This information includes updated program dates and deadlines.

Wellness Credit Period

The **Wellness Credit Period** is the period of time in which qualifying participants will receive the Wellness Credit. Wellness Credit Periods for the Health Rewards program are as follows:

- **2023 Wellness Credit Period**
  January 1 – December 31, 2023 (Deadline to qualify, October 28, 2022)

Qualifying Period

The **Qualifying Period** is the set period of time in which eligible employees can complete qualifying wellness activities to earn points toward the Wellness Credit. Qualifying Periods for the Health Rewards program are as follows:

- **January 1 – October 28, 2022**
  Qualifying period for the 2023 Wellness Credit

update to health rewards

update to the summary plan description

effective january 1, 2021

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health rewards chapter

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Wellness Credit Period

The **Wellness Credit Period** is the period of time in which qualifying participants will receive the Wellness Credit. Wellness Credit Periods for the Health Rewards program are as follows:

- **2022 Wellness Credit Period**
  January 1 – December 31, 2022 (Deadline to qualify, November 12, 2021)

Qualifying Period

The **Qualifying Period** is the set period of time in which eligible employees can complete qualifying wellness activities to earn points toward the Wellness Credit. Qualifying Periods for the Health Rewards program are as follows:

- **January 1 – November 12, 2021**
  Qualifying period for the 2022 Wellness Credit

This 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.

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.

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**.

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.

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.

legal guardian clarification
effective january 1, 2021

human energy. yours.™

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

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

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benefit contact information

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

WebMD Health Services (WebMD)

The administrator for the Chevron Healthy You program and points tracking for Health Rewards, including the Wellness Credit.

Why contact this administrator

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

Phone information

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

Website information

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

Other contact information

- heart@chevron.com
- **WebMD Wellness At Your Side** mobile app available on the Apple App Store or Google Play.

2nd.MD

The administrator for the Chevron Health Decision Support Program.

Why contact this administrator

- To request a second opinion offered as part of the Health Decision Support Program.

Phone information

- 1-866-818-7751

Website information

- To activate your account, learn about the program's services, or to request a second opinion.
- **www.2nd.md/chevron**

Other contact information

- chevron@2nd.MD
- **2nd.MD** mobile app available on the Apple App Store or Google Play.

Omada Health (Omada)

Administrator for the Chevron Diabetes Prevention Program.

Why contact this administrator

- For detailed information or support regarding eligibility for, application to, or participation in the Diabetes Prevention Program.

Phone information

- 1-888-409-8687

Website information

- www.omadahealth.com/chevron

Other contact information

- support@omadahealth.com

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.

Summary Plan Descriptions

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

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

Human Resources Service Center (HR Service Center) *and* BenefitConnect Website

Why contact this administrator

- Ask about your or your dependents' eligibility to participate in Chevron benefit plans.
- Request a printed copy of summary plan descriptions (SPD).
- Ask about eligibility for health rewards and the Wellness Credit.

Phone information

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

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

Website information

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

BenefitConnect | COBRA

Claims administrator for COBRA continuing coverage for Chevron health plans.

Why contact this administrator

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

Phone information

- **n**
- Monday through Friday
- 6:00 a.m. to 4:00 p.m. Pacific Time (8:00 a.m. to 6:00 p.m. Central Time) excluding holidays

Website information

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

who's eligible to participate

This section provides *general* information about wellness program eligibility rules for you and your dependents. **Each individual wellness program may have other specific eligibility requirements in addition to those described in this section. See each program for additional eligibility requirements.**

eligible employees

eligible spouse

eligible domestic partner

eligible children or other dependents

eligible employees

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

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

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

- You're not on the Chevron U.S. payroll, or you're compensated for services to Chevron by an entity other than Chevron — even if, at any time and for any reason, you're deemed to be a Chevron employee.
- You're a leased employee or would be a leased employee if you had provided services to Chevron for a longer period of time.
- You enter into a written agreement 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 Chevron's wellness programs. Subject to the Plan's administrative review procedures, Chevron Corporation's determination is conclusive and binding.

If you have questions about your eligibility for the Omnibus Health Care Plan, you should contact the Chevron Human Resources Service Center.

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

Non-U.S.-payroll expatriates working in the United States that are eligible for the **Global Choice Plan (Expatriates in the U.S.)** while on expatriate assignment may also be eligible for certain wellness programs. Non-U.S.-payroll expatriates should refer to the **Health Benefits for Expatriates in the U.S.** summary plan description for information about wellness programs that are available to you.

eligible spouse

Spouse participation varies from program to program. Go to each particular wellness program included in this summary plan description to see if spouses are eligible to participate. The general requirements for an eligible spouse for purposes of the wellness programs are described below.

Your spouse must be eligible for coverage under a Chevron medical plan that is part of the Omnibus Health Care Plan. In addition, your spouse is considered eligible if you're legally married under the law of a state or other jurisdiction where the marriage took place.

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

eligible domestic partner

Domestic partner participation varies from program to program. Go to each particular wellness program included in this summary plan description to see if domestic partners are eligible to participate. The general requirements for an eligible domestic partner are described below.

Your domestic partner must be eligible for coverage under a Chevron medical plan that is part of the Omnibus Health Care Plan.

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 by calling the HR Service Center.

By signing the affidavit, you certify that you and your partner meet one of the following qualifications:

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

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

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

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

5. You meet other criteria set forth in the **Chevron Affidavit of Domestic Partnership (F-6)**.

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.

eligible children or other dependents

Child and other dependent participation may vary from program to program. Go to each particular wellness program included in this summary plan description to see if children or other dependents are eligible to participate. The general requirements for an eligible child or other dependent are described below.

Your child is considered eligible for the wellness programs 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.

An "other dependent" is considered eligible 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.

Incapacitated Child

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.

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.

health rewards

From time to time Chevron may offer health rewards in recognition of personal commitment to get and stay healthy. This section describes what health rewards are, specific eligibility information and participation requirements to receive them.

program overview

eligibility

when participation starts

wellness credits

when participation ends

program overview

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

Take control of your health and improve your health habits as you earn points toward health rewards. Health rewards are Chevron's way of recognizing your personal commitment to get and stay healthy. Your participation is voluntary.

With the Health Rewards program, you can complete **qualifying wellness activities** to accumulate **points**. If you accumulate the required points by the **annual deadline** and meet all of the program **eligibility requirements**, you can qualify for the **Wellness Credit**.

Learn more about the Health Rewards program online at **hr2.chevron.com/wellness**.

eligibility

Employees

U.S.-payroll employees who are eligible for Chevron's health plans can participate in the Health Rewards program. See the **Who's Eligible to Participate** chapter in this summary plan description for the detailed eligibility requirements. In addition, note that:

- You don't actually have to be enrolled in a qualifying Chevron-sponsored medical plan to complete **qualifying activities** and **accumulate points** toward the **Wellness Credit**.
- However, to receive your **Wellness Credit**, you must be enrolled in a qualifying Chevron-sponsored medical plan *and* meet the additional Wellness Credit eligibility requirements. See Wellness Credit eligibility requirements below for information.

Wellness Credit eligibility requirements

If you are a U.S.-payroll employee eligible to participate in Health Rewards, you must *also* meet *all* these additional requirements to qualify to receive the Wellness Credit:

- You must **complete the specific Wellness Credit requirements** by the stated annual deadlines. Review the **How to Qualify** section in this **Health Rewards** chapter for information.
- You must be a **current U.S.-payroll employee** who is eligible for coverage in Chevron health plans on the date your Wellness Credit is applied.
- You must be **enrolled** in Chevron-sponsored medical plan on **January 1** of the **Wellness Credit Period.**
- You must continue to be enrolled in a Chevron-sponsored medical plan for the **duration of the Wellness Credit Period**.

Spouses and Domestic Partners

While your spouse/domestic partner may be able to participate in certain wellness activities, your spouse/domestic partner cannot earn points, qualify for Wellness Credits or otherwise participate in the Health Rewards program.

If both you and your spouse/domestic partner are Chevron U.S.-payroll employees**,** you can both qualify for and receive the Wellness Credit if you are both covered *separately* on a qualifying Chevron-sponsored medical plan. However, if one of you is enrolled as dependent, the employee that is enrolled as a dependent is not eligible to receive the Wellness Credit.

Children and Other Dependents

While your eligible children and other eligible dependents may be able to participate in certain wellness activities, they cannot earn points, qualify for Wellness Credits or otherwise participate in the Health Rewards program.

Newly Hired or Rehired Employees

Employees newly hired or rehired are not eligible to receive the Wellness Credit available during the Wellness Credit Period of the year of hire. However eligible new employees are encouraged to work toward the next available Wellness Credit, if hired prior to the deadline to qualify.

For example:

- **Hired April 1, 2020:** You're not eligible to receive the 2020 Wellness Credit (January 1 – December 31, 2020). You are, however, eligible to earn points by October 30, 2020 to qualify for the 2021 Wellness Credit.

- **Hired December 1, 2020:** You're not eligible to receive the 2020 Wellness Credit (January 1 – December 31, 2020). You are also not eligible to receive the 2021 Wellness Credit because the deadline to qualify – October 30, 2020 – has passed.

wellness credit

*This section generally describes the Chevron Corporation policy as of **January 1, 2020**, regarding its Wellness Credit, which is a reduction to the cost of a participant's Chevron medical coverage as described below. This section is not a plan text, a summary plan description or a summary of material modification because the amount of the company contribution and how it is determined is not itself part of a medical plan. Nevertheless, if it should be determined to be part of a medical plan, this document 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 this document may be subject to collective bargaining and, therefore, may not apply to union-represented employees.*

What is the Wellness Credit?

The Wellness Credit is a premium reduction of up to $750 annually on qualifying Chevron-sponsored medical plan coverage premiums from **January 1** through **December 31** of the applicable **Wellness Credit Period**.

Wellness Credit Period

The **Wellness Credit Period** is the period of time in which qualifying participants will receive the Wellness Credit. Wellness Credit Periods for the Health Rewards program are as follows:

- **2018 Wellness Credit Period**
  January 1 – December 31, 2018 (Deadline to qualify, October 27, 2017)
- **2019 Wellness Credit Period**
  January 1 – December 31, 2019 (Deadline to qualify, October 26, 2018)
- **2020 Wellness Credit Period**
  January 1 – December 31, 2020 (Deadline to qualify, October 25, 2019)
- **2021 Wellness Credit Period**
  January 1 – December 31, 2021 (Deadline to qualify, October 30, 2020)

Who is Eligible to Receive the Wellness Credit?

Review the **Eligibility** section in this **Health Rewards** chapter for information.

How to Qualify for the Wellness Credit

Review the **How to Qualify** section in this **Health Rewards** chapter for information.

How the Wellness Credit Works

Eligible Wellness Credit recipients will receive a premium reduction of up to $750 annually on qualifying Chevron-sponsored medical plan coverage premiums from January 1 through December 31 of the applicable Wellness Credit Period, as long as you remain an eligible employee enrolled in a qualifying Chevron-sponsored medical plan during the Wellness Credit Period.

Here's how the Wellness Credit works:

- If you are eligible to receive the Wellness Credit on January 1, the applicable premium reduction will automatically be applied to your paycheck. No additional action to start the premium reduction is required from you.
- Your applicable premium reduction will be taken in equal installments during the Wellness Credit Period, or for as long as you remain an eligible employee enrolled in a qualifying Chevron-sponsored medical plan, whichever comes first.
- Your applicable premium reduction will be applied toward the employee contribution portion of the monthly premium of a qualifying Chevron-sponsored medical plan.
- The premium reduction applies only to qualifying Chevron-sponsored medical plan coverage premiums. The premium reduction does not apply to dental, the Vision Plus Program, mental health and substance use disorder coverage, COBRA coverage, any of the Chevron retiree health coverage options, or any non-Chevron-sponsored medical plan coverage.
- Eligible Wellness Credit recipients will continue to be responsible for actual medical services and charges including (but not limited to) copayments, coinsurance, deductibles and other out-of-pocket expenses.
- You cannot receive the Wellness Credit in cash or any other form to be used toward medical or other personal out-of-pocket expenses.
- The Wellness Credit is not prorated based on the number of points earned; you must earn the required points each year to qualify for the Wellness Credit. In addition, no additional premium reduction is available for earning *more than* the required points.

Qualifying Chevron-sponsored employee medical plan

A qualifying active employee medical plan under the Omnibus Health Care Plan (referred to hereafter as "qualifying Chevron-sponsored medical plan") currently includes:

- Chevron Medical PPO Plan
- Chevron High Deductible Health Plan (HDHP)
- Chevron High Deductible Health Plan Basic (HDHP Basic)
- Chevron Medical HMO Plans
- Global Choice Plan (U.S.-Payroll Expatriates)

Basis of annual premium reduction amount

If eligible for the Wellness Credit, your applicable premium reduction amount will be based on your qualifying Chevron-sponsored medical plan option, coverage level, cost and enrolled dependents on January 1 of the applicable Wellness Credit Period, as follows:

- The premium reduction applies to any of the available **coverage level** choices: You Only, You + One Adult, You + Child(ren), You + Family.
- The qualifying Chevron-sponsored medical plan in which you are enrolled on January 1, of the applicable Wellness Credit Period will be used to calculate your premium reduction amount.
- If you are not enrolled in a qualifying Chevron-sponsored medical plan on January 1 of the applicable Wellness Credit Period, you are ineligible to receive the Wellness Credit, even if you earned the required points by the deadline.

The annual premium reduction amount for eligible Wellness Credit recipients is determined as follows:

- If the employee share of the annual premium cost of your elected, qualifying Chevron-sponsored medical plan costs **less than $750**, you'll only receive up to the annual employee share amount of the cost of your elected plan. For example, if the annual employee cost of your elected plan is $600, you will receive an annual premium reduction of up to $600. You will not receive the $150 difference in cash or in any other form.
- If the employee share of the annual premium cost of your elected, qualifying Chevron-sponsored medical plan costs **more than $750**, you'll only receive up to the $750 maximum premium reduction amount. For example, if the annual employee cost of your elected plan is $4,000, you will receive an annual premium reduction of up to $750. You will be responsible for paying the remaining $3,250 in annual employee cost.

Please note: Remember, if you qualify, the premium reduction will not take effect until January1 of the applicable Wellness Credit Period. As is the course of standard business in the health care industry, monthly employee medical premiums for the new year will not be available until the open enrollment period each fall. Your open enrollment communications will provide additional details about the monthly amount of the premium reduction for those who qualify, including how to review the amount of your premium reduction.

Chevron Couples

If both you and your spouse or domestic partner or child(ren) are Chevron U.S.-payroll employees, you can **each** qualify for the Wellness Credit if you meet the eligibility requirements **to participate**. However please note:

- If each of you are **primary** – in other words, enrolled separately – in your own qualifying Chevron-sponsored medical plan coverage then each of you must qualify *separately* for the Wellness Credit. If you each qualify, you are each eligible for the Wellness Credit that is applied toward each of your separate medical plans, respectively.
- If one of you is primary and the other(s) is covered as your **dependent** in a qualifying Chevron-sponsored medical plan, then only you, as the primary, are eligible for the Wellness Credit. You, the primary, must meet the eligibility requirements to receive the Wellness Credit. If you qualify, you are eligible for only one Wellness Credit that is applied toward your qualifying Chevron-sponsored medical plan. In this situation, the dependent – although an eligible employee – cannot receive a Wellness Credit because they are enrolled as a dependent.

Mid-Year Changes

If you experience a qualifying life event between January 2 and December 31 of the applicable Wellness Credit Period that permits you to make a change to your qualifying Chevron-sponsored medical plan coverage, the Wellness Credit is affected as follows.

Eligible to receive the Wellness Credit on January 1 of the applicable Wellness Credit Period:

- If you **continue to participate** in a qualifying Chevron-sponsored medical plan, you will continue to be eligible to receive the Wellness Credit, as long as you remain an eligible employee for the duration of the applicable Wellness Credit Period.

- If you **continue to participate** in a qualifying Chevron-sponsored medical plan, the amount of your annual premium reduction may be increased or decreased, depending on the plan and coverage level you choose. See the **Basis of Annual Premium Reduction Amount** above for more information.

- If you **stop participating** in a qualifying Chevron-sponsored medical plan, you are no longer eligible to receive the Wellness Credit and you forfeit the remainder of your annual premium reduction amount for the Wellness Credit Period effective the date your coverage ends. You will not be paid the balance of the annual premium reduction you were potentially eligible to receive in cash or in any other form.

Not eligible to receive the Wellness Credit on January 1 of the applicable Wellness Credit Period:

- If you experience a qualifying life event that permits you to **start participating** in a qualifying Chevron-sponsored medical plan *and* you were not previously enrolled in a qualifying Chevron-sponsored medical plan, you are not eligible to start receiving the Wellness Credit, even if you earned the required points by the deadline of the previous year. This is because you did not meet the eligibility requirement of being enrolled in a qualifying Chevron-sponsored medical plan on January 1 of the applicable Wellness Credit Period.

When you leave Chevron

If you leave Chevron between January 2 and December 31 of the applicable Wellness Credit Period – whether due to retirement or for any other voluntary or involuntary reasons – and you were previously eligible to receive the Wellness Credit, then you are no longer eligible to receive the Wellness Credit. You will forfeit the remainder of your annual premium reduction amount for the Wellness Credit Period effective the date your coverage ends as an eligible employee. You will not be paid the balance of the annual premium reduction you were potentially eligible to receive in cash or in any other form.

how to qualify for the wellness credit

How to Qualify

To qualify for Health Rewards and the Wellness Credit you must:

- Meet the **eligibility requirements** to participate in Health Rewards.
- Register on the **WebMD Healthy You Program website** to complete and log qualifying activities for points. *All points must be logged on the WebMD website during the current qualifying period.*
- Each time you complete and log a **qualifying wellness activity**, you'll earn points.
- **Accumulate 1,000 points** during the applicable qualifying period by the stated deadline.
- Meet the additional **Wellness Credit eligibility requirements**.

Remember, U.S. payroll employees who are eligible for Chevron's health plans may earn points; however, you must *also* meet the Wellness Credit eligibility requirements at the time you receive credit *and* for the duration of the Wellness Credit Period.

Note that each year, after the qualifying period deadline has passed, the **health rewards** section on the **WebMD website** will be temporarily unavailable until a new qualifying period is opened.

Qualifying Period

The **Qualifying Period** is the set period of time in which eligible employees can complete qualifying wellness activities to earn points toward the Wellness Credit. Qualifying Periods for the Health Rewards program are as follows:

- **January 1 – October 27, 2017**
  Qualifying period for the 2018 Wellness Credit
- **January 1 – October 26, 2018**
  Qualifying period for the 2019 Wellness Credit
- **January 1 – October 25, 2019**
  Qualifying period for the 2020 Wellness Credit
- **January 1 – October 30, 2020**
  Qualifying period for the 2021 Wellness Credit

Qualifying Activities and Points

The list of qualifying activities and their associated point value may change from year to year. The complete list of qualifying activities, requirements and available points are posted each qualifying period online on the **Health Rewards** section of **hr2.chevron.com/wellness** as well as on the health rewards section of the **WebMD Healthy You Program website.**

There are a variety of activities spanning five categories to choose from to earn points. For example, points may be available when you participate in some of Chevron's wellness programs – such as the Healthy You program, Health Decision Support, or the Diabetes Prevention Program – or when you use your Chevron benefits to monitor and maintain your health. There are also opportunities to earn points independent of Chevron resources. While you have flexibility to choose as many activities from any combination of the five categories, some activities and categories have a maximum number of points that can count toward your total goal. Many of the activities require advance scheduling and time to complete, so allow plenty of time to accumulate the required points before the deadline. **Points do not roll over from year to year.**

If you have a health condition and don't think you can meet a standard for qualifying for health rewards and the Wellness Credit, you might be eligible for an opportunity to earn the same reward by different means. Send an email to **heart@chevron.com** and we will work with you to find alternative activities that are right for you considering your health status.

when participation starts

To start participating in health rewards and earn points toward the Wellness Credit:

- Register on the WebMD Healthy You program website.
- Complete a qualifying wellness activity.

You are eligible to start earning points on your hire date or on the date you first become eligible, whichever comes first.

when participation ends

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

- You are no longer eligible. Participation ends on the last day of the month that eligibility ends.
- Chevron Corporation terminates the Omnibus Health Care Plan or a particular wellness program offered under the plan.
- After 31 days of the following types of leave:
  - Personal Leave Without Pay.
  - Leave for educational reasons.
  - Long Union Business Leave (unless you elect to pay 100% of the cost of continued health coverage).

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

Individuals eligible to participate who have a qualifying event under the Continuation Coverage and COBRA Coverage provision of the Omnibus Health Care Plan (for example, a termination of employment) can choose to continue participation in the Healthy You Program and Health Rewards but *may not qualify for the Wellness Credit*. Continuation lasts for up to the length of time described in the **Continuation Coverage and COBRA Coverage** chapter of this summary plan description or until the particular wellness program is terminated, whichever comes first.

confirmation of wellness credit

For current instructions about how to view a confirmation of your Wellness Credit, or if you believe you are eligible for a Wellness Credit and are not receiving it, visit the **Health Rewards** section on **hr2.chevron.com**.

healthy you program

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

program overview

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program overview

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

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

The program includes the following services provided by WebMD:

- **A personal WebMD Healthy You account**. You can register for you own personal WebMD Healthy You account. This is similar to a publicly available WebMD account, but the website available has been created for Chevron, with specific links to Chevron resources and programs. You can access your account anywhere online or with the mobile app.
- **Voluntary health questionnaire (HQ).** The WebMD online health questionnaire is voluntary and confidential and takes approximately 15 minutes to complete. It will help you identify your health risk factors through a series of basic questions about your health and certain health numbers. Using this information, you will be provided with a personal report highlighting your risk factors and a suggested action plan with goals to help you maintain your health or to make healthy changes.
- **A personal action plan.** After you complete the health questionnaire, you'll be presented with a suggested plan of action with goals, ideas and resources to maintain your health or to reduce or manage your health risk factors (if any). These recommendations will be tailored to your personal situation based on the results of your health questionnaire.
- **A personal health coach.** After you take the voluntary HQ, you'll have the option to be paired with a professional WebMD Health coach who can work with you and provide support on your personal health goals. Coaches are not Chevron employees; they are WebMD employees. You meet with your coach by phone and by online or in-app messaging, at your convenience. You direct the conversation around issues and goals that matter to you. Discussing the results of your HQ is often a good starting point for your conversation.
- **My Health Assistant.** This is an interactive, online tool to help you set, meet and track your health goals. After you select your goals, the My Health Assistant lets you choose from a number of simple activities that become part of your weekly plan to support those goals. These activities have been created and developed by WebMD health coaches.
- **Health record and trackers.** Use your Health Record to store, maintain, track and manage your health information in one centralized, private and secure location. You can document details such as your personal health numbers, conditions, medications, information about your medical visits and more. You can upload medical and general documents and keep up with your medical contacts. You can even print this information out to take with you to a doctor’s visit. Use the trackers to enter in specific information to see your progress over time.

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

- In addition to participating in the wellness activities, resources and tools above, the **WebMD Healthy You Program website** is also the place to go to review, complete and log qualifying activities for points toward Health Rewards, if desired.

Learn more about the Healthy You Program online at **hr2.chevron.com/HealthyYou**. If you have questions about the Chevron Healthy You Program, send an email to **heart@chevron.com**.

eligibility

Employees

The Healthy You program is available to U.S. – payroll employees eligible for Chevron's health plans. See the **Who's Eligible to Participate** chapter in this summary plan description for the detailed eligibility requirements. You don't actually have to be enrolled in a Chevron health plan to participate; you just have to be eligible to participate in the plans, if desired.

Spouses and Domestic Partners

Your spouse or domestic partner can participate in Healthy You if eligible to be covered by you under Chevron's health plans. See the **Who's Eligible to Participate** section in this summary plan description for the detailed eligibility requirements. Your spouse or domestic partner doesn't actually have to be enrolled in a Chevron health plan to participate; they just have to be eligible to participate in the plans, if desired. Eligible spouses and domestic partners can use all program resources, including coaching.

Children and Other Dependents

Your children and Other dependents age 18 years and older can participate in Healthy You if eligible to be covered by you under Chevron's health plans. See the **Who's Eligible to Participate** section in this summary plan description for the detailed eligibility requirements. Your child or Other dependent doesn't actually have to be enrolled in a Chevron health plan to participate; they just have to be eligible to participate in the plans, if desired. Eligible child or Other dependents age 18 years and older cannot use coaching, but all other program tools and resources are available. Dependents under age 18 cannot participate at this time.

cost to participate

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

when participation starts

To start participation in the Healthy You program, you must first register for the program on a third-party website, currently managed by WebMD Health Services. Next, you can complete the confidential health questionnaire and begin using the available tools and resources. You are eligible to start participation on your hire date or on the first day you become eligible, whichever comes first.

How to Register and Start Participating

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

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

- Go to **hr2.chevron.com/HealthyYou**.
- Follow the instructions on the screen to register an account, if applicable.
- Eligible dependents will need the employee’s CAI to register on the site and create a username and password.

when participation ends

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

- You or your dependent is no longer eligible. Participation ends on the last day of the month that eligibility ends.
- Chevron Corporation terminates the Omnibus Health Care Plan or a particular wellness program offered under the plan.
- After 31 days of the following types of leave:
  - Personal Leave Without Pay.
  - Leave for educational reasons.
  - Long Union Business Leave (unless you elect to pay 100% of the cost of continued health coverage).

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

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

confidentiality

Only you, WebMD, Chevron health care plans, and certain third party health care plan vendors will have access to your individual health questionnaire results. Individually identifiable data will only be disclosed in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). Chevron has authorized WebMD to contact employees to invite them to use the website's tools and resources. You can opt out of WebMD communications if you choose.

Except as explained above, the information that you provide WebMD is available only to you and those you authorize. For instance, if necessary, for your own health management, you may wish to share your personal information with others such as your doctor, emergency rooms or other healthcare providers. Please read WebMD's privacy policy for a full explanation as to how your health information will be handled and disclosed by WebMD. Here's a summary of some important points:

- Unless permitted by HIPAA, specifically authorized by you, or legally required, WebMD will not release any data in which individuals can be personally identified. As indicated above, Chevron health care plans and certain third party health care plan vendors may have access to your individual health questionnaire results.
- WebMD does analyze data and produce reports for client organizations, but only using data collected from large populations of users. Such aggregate data cannot be used to identify any individuals. Clients use aggregate data to better understand the needs of their organization and design appropriate health improvement programs to meet those needs.
- WebMD helped create the Hi-Ethics Principles as a founding member of the Hi-Ethics alliance. They are committed to helping consumers improve their health and the health of their families. WebMD has received e-Health accreditation and privacy seal awards from URAC (formerly the American Accreditation HealthCare Commission), TRUSTe and HON for high quality standards and privacy practices.

health decision support

Health Decision Support is available to help you when you're faced with a health decision.

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program overview

Health Decision Support is available to help you when you're faced with an important medical decision. Based on the traditional practice of getting a second opinion, but with additional features, this service works with leading medical specialists to review your case and then provide feedback on your diagnosis and treatment plan. Health Decision Support is another resource for you to collect information about your diagnosis and treatment plan so you can make informed decisions about your care.

Innovation Specialists LLC 2nd.MD (**2nd.MD**) is the administrator for the Health Decision Support Program.

For example, this second medical opinion service could be used when you or an eligible dependent:

- Are facing a new medical diagnosis.
- Have questions about your treatment plan or medications.
- Are considering possible surgery.
- Are managing ongoing medical conditions.

With your permission, the 2nd.MD team will collect and analyze all your relevant medical records and then connect you with a specialist, via phone or video, to discuss your case and conduct a full review of your diagnosis and treatment plan.

2nd.MD can help you possibly avoid unnecessary procedures, spot misdiagnoses and improve existing treatment plans. Sometimes the second opinion might confirm your current course of action; other times it might provide a different viewpoint.

You are under no obligation to follow the recommendations provided by 2nd.MD. In fact, you're strongly encouraged to share the information with your doctor and discuss next steps or options together.

eligibility

Employees

In addition to meeting the eligibility requirements included in the **Who's Eligible to Participate** chapter of this summary plan description, you must **also** be enrolled in either the Chevron Medical PPO Plan, Chevron High Deductible Health Plan (HDHP), High Deductible Health Plan Basic (HDHP Basic), a Chevron Medical HMO Plan or the Global Choice Plan (U.S.-Payroll Expatriates).

Spouses and Domestic Partners

Your spouse or domestic partner can use Health Decision Support if covered by you under either the Chevron Medical PPO Plan, Chevron High Deductible Health Plan (HDHP), High Deductible Health Plan Basic (HDHP Basic), a Chevron Medical HMO Plan or the Global Choice Plan (U.S.-Payroll Expatriates).

Children and Other Dependents

Your children and Other dependents can use Health Decision Support if covered by you under either the Chevron Medical PPO Plan, Chevron High Deductible Health Plan (HDHP), High Deductible Health Plan Basic (HDHP Basic), a Chevron Medical HMO Plan or the Global Choice Plan (U.S.-Payroll Expatriates).

how to enroll

Health Decisions Support is automatically available to employees and their dependents who meet the eligibility requirements to participate. Enrollment is not required.

cost to participate

Health Decision Support is automatically included in your health benefits with no copayments or coinsurance. Although Health Decision Support is provided at no additional cost to you, please be aware that any additional tests or services you elect to undertake as a result of information contained in your second opinion report will be paid according to the provisions of your selected health plan. If you have a concern regarding the cost of any additional test or service, it is recommended that you check with your health plan before proceeding.

how it works

Step One

To get started, contact a 2nd.MD nurse through any of these methods:

- www.2nd.md/chevron
- 1-866-818-7751
- Chevron@2nd.MD
- From the 2nd.MD mobile app

Step Two

When you contact 2nd.MD, a nurse will speak with you to understand your condition. This nurse will be with you through all steps of the process and will do much of the work for you.

- Your nurse will send an electronic **release of information form (ROI form)** through the 2nd.MD website which you can sign electronically through the web. If necessary, the nurse can also issue and receive the ROI form via fax or next-day FedEx. (Note that next-day FedEx may slightly delay your second opinion response time).
- Once you sign and return the ROI form, your nurse will coordinate with the 2nd.MD records team to retrieve all necessary **medical records for the consult**. 2nd.MD is a concierge service, so you will not need to collect any medical records on your own.
- On average, the time between when 2nd.MD receives your completed ROI form and when you are speaking with a leading medical specialist regarding your second opinion is **three business days**.

Step Three

After understanding your medical condition and determining what type of specialist is best for your case, your 2nd.MD nurse will work with you to select a specialist and schedule a mutually convenient time for both of you to have the consult — including nights and weekends. You'll be able to **speak directly with a specialist about your condition**. Consultations are conducted by video or phone, and at a time that works for you. Your family, friends or your treating physician can also participate in the consult if you wish.

Step Four

After speaking with the specialist, you will receive a **written summary of the consultation**. The 2nd.MD nurse team will always be available to answer any questions after the consult and support you in finding local doctors. Based on the information you learned during your conversation with a leading specialist, discuss your treatment options with your family and your current doctor.

musculoskeletal surgery requirement

Chevron requests that you seek a second opinion through the Health Decision Support Program prior to receiving **knee, hip, back** or **spine surgery** (on a non-emergency basis). It's your choice to use the second opinion service *or* decline to use the second opinion service for these four procedures. **However, if you do not seek a second opinion for these procedures you will be responsible for an additional $400 of out-of-pocket costs for the procedure, whether or not you've met your annual deductible.**

- This requirement currently only applies to **eligible employees** enrolled in the Chevron Medical PPO Plan, Chevron High Deductible Health Plan (HDHP) or High Deductible Health Plan Basic (HDHP Basic).
- This requirement does not currently apply to enrolled dependents or COBRA participants enrolled in these plans.
- The administrator is available for second medical opinions about more than just these four procedures, but it's only the knee, hip, back and spine surgery procedures that will affect your out-of-pocket costs for the procedure at this time.
- Second opinion medical consultations are conducted by phone or through a video conference on your computer, at a time that's convenient for you. You don't have to travel or go to an office for this advice.

Am I required to follow the advice of the second opinion?

It's always your decision whether to follow the second opinion or stay the course on your original treatment plan. Chevron is simply asking that you seek an expert second opinion through the Health Decision Support service to help you make informed decisions about your care before your knee, hip, back or spine procedure.

How long does it take to receive a second opinion?

The intention is to make getting this second opinion as easy as possible. On average, the time between when the administrator receives your completed form and when you are speaking with a leading specialist regarding your second opinion is three business days.

What's considered an emergency?

Your procedure is considered an emergency if your doctor recommends the surgery be scheduled in seven days or less. You are still encouraged to use the 2nd.MD service, but it will not affect the outcome of your out-of-pocket costs for the procedure.

confidentiality

2nd.MD will not share your medical records or the outcome of your second medical opinion with anyone at your medical plan unless you specifically authorize such disclosure, with one exception:

- If you are enrolled in the Medical PPO Plan, the High Deductible Health Plan or the High Deductible Health Plan Basic, your authorization will not be required for 2nd.MD to share information with the medical plan claims administrator for payment purposes if you obtain a second opinion prior to a qualifying knee, hip, back or spine surgery.
- 2nd.MD will only share basic information, including your name, so that the medical plan claims administrator can determine if the additional $400 out-of-pocket cost does or does not apply to you.

In addition, 2nd.MD endeavors to comply with all relevant state, national, and international laws and regulations including the U.S. Health Insurance Portability and Accountability Act (HIPAA) of 1996. You can find their Privacy Policy at **www.2nd.md/privacy-policy**.

exclusions

Certain types of cases cannot be reviewed by 2nd.MD. The 2nd.MD program does not provide consulting services for cases being covered under Workers Compensation. Call 2nd.MD if you are unsure if your case can be reviewed.

when participation starts

You and your eligible dependents are eligible to use Health Decision Support on the effective date of your coverage in the Chevron Medical PPO Plan, a Chevron Medical HMO Plan, the Chevron High Deductible Health Plan, the Chevron High Deductible Health Plan Basic or the Global Choice Plan (U.S.-Payroll Expatriates).

when participation ends

Participation in Health Decision Support will end if any of the following occurs:

- You or your dependent is no longer eligible. Participation ends on the last day of the month that eligibility ends.
- Chevron Corporation terminates the Omnibus Health Care Plan, or a particular wellness program offered under the plan.
- After 31 days of the following types of leave:
  - Personal Leave Without Pay.
  - Leave for educational reasons.
  - Long Union Business Leave (unless you elect to pay 100% of the cost of continued health coverage).

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

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

diabetes prevention program

The Chevron Diabetes Prevention Program is an online behavioral modification and digital care program designed to help individuals at risk for type 2 diabetes make gradual changes to the way they eat, move, sleep and manage stress.

program overview

The **Chevron Diabetes Prevention Program**, administered by the third-party provider **Omada Health**, is an online behavioral modification and digital care program designed to help individuals at risk for type 2 diabetes make gradual changes to the way they eat, move, sleep and manage stress.

The program includes the following services and resources provided by Omada to help participants build lasting healthy habits:

- A one-minute, **confidential online risk screener** that asks a few questions about height, weight, and health conditions. The screener is used to identify if you might be at high risk for developing diabetes. If you are considered at high risk for diabetes, you are able to complete an online application to participate in the program.

- Those who meet the clinical eligibility criteria will receive an email invitation to enroll in the program which includes:
  - A professional **health coach** for one-on-one guidance. A coach can keep you on track, on your best days and your worst.
  - A **wireless scale** to monitor progress. You will receive this ready-to-use device in the mail, already synced so that you can confidentially share your weight with your health coach and track your weight loss progress.
  - Weekly **online lessons** to educate and inspire. During the course of the program, you are guided through online lessons that tackle physical, social, and psychological components of healthy living. **Interactive activities** reinforce learning and help you make connections to real-world scenarios.
  - A small **peer group for real-time support**. Participants are matched with other participants for added encouragement and accountability. Participate in the group as much or as little as you feel comfortable with. Note that peer groups are built from all individuals participating in Omada's programs and are not limited solely to other Chevron employees.

This program is focused on helping individuals who are at risk for type 2 diabetes. This means that while all eligible employees are invited to take the initial confidential online risk screener, only employees that meet certain clinical eligibility criteria will be eligible to enroll in the program and make use of the full resources and services offered by Omada.

The Omnibus Health Care Plan permits wellness programs to be offered under the terms and conditions established by Chevron. As such, the Chevron Diabetes Prevention Program is part of the Omnibus Health Care Plan.

eligibility

The following Chevron Diabetes Prevention Program eligibility requirements provide access to *only* the initial, **Omada confidential online risk screener**:

- You must be a current U.S.-payroll employee who meets all the requirements of an **eligible employee** as described in the **Who's Eligible to Participate** chapter of this summary plan description.
- You must be age **18 years or older**.
- You are not required to be enrolled in a Chevron-sponsored medical plan; you just need to be eligible to participate in such plans, if desired.
- Your dependents - spouse, domestic partner, children – are *not* eligible to participate in the Chevron Diabetes Prevention Program (unless they are also eligible employees of Chevron).
- U.S.-payroll employees on an expatriate assignment are *not* be able to participate in the Chevron Diabetes Prevention Program.
- The Chevron Diabetes Prevention Program is *not* available to retirees.

In addition to the above, you must *also* satisfy the following clinical eligibility requirements to be able to **enroll in and participate in the program**, which includes a professional health coach, a wireless scale and associated tracking technology, online lessons, and peer group support.

- The results of your confidential online risk screener indicate you meet current at risk clinical eligibility criteria as defined by Omada. See **Clinical Eligibility Criteria** for further details.
- You complete the subsequent online application from Omada and, after further clinical review, Omada accepts your application.
- If any of the clinical exclusions - as defined by Omada - apply to you, you are *not* eligible to participate in the Chevron Diabetes Prevention Program.

Chevron Couples

If both you and your spouse or domestic partner are eligible Chevron U.S.-payroll employees, you can both participate in the program if you meet the clinical eligibility requirements.

Clinical Eligibility Criteria

Omada must approve your application for you to participate in the program, and you must meet the following criteria defined and managed by Omada:

Obese		**Overweight* with one or more risk factor(s)**			
BMI ≥ 30	**OR**	Prediabetes	Hypertension	Dyslipidemia	Tobacco Use

*Overweight means BMI ≥25 or ≥23 if of Asian descent.

If Omada, in its sole discretion, believes that the circumstances of a your enrollment in the Diabetes Prevention Program may put your health or safety at risk (including any instances where you consistently fail to follow the recommendations of Omada), Omada may deny your application or remove you from enrollment in the Diabetes Prevention Program. The clinical eligibility criteria may be amended or modified from time to time by Omada, in its sole discretion.

how it works

Step One

Take the confidential online risk screener to determine if you may be at risk for type 2 diabetes

If you are an eligible employee and interested in the Omada program, the first step is to take the **confidential online risk screener** that asks a few questions about height, weight, and health conditions. The screener is used to identify if you might be at high risk for developing diabetes. If you are considered at high risk for diabetes, you are able to complete an application to participate in the program. You can access the screener in either one of these ways:

- Go to the **Diabetes Prevention Program** page on **hr2.chevron.com**.
- Access the tool directly at **www.omadahealth.com/chevron**.
- Be aware that you will likely need access to the Chevron computing network to locate your personal Chevron identification number that is used to verify your eligibility to take the confidential online risk screener. You do not, however, need intranet access to take the screener or use the Omada tools.

Step Two

Complete online application

You'll receive the results instantly after completing the screener. If the results indicate you may be at risk for type 2 diabetes, you will then be able to complete a brief online application that typically takes less than 10 minutes. This online application provides Omada with more information about your health history to determine if any of the program's exclusion criteria applies to you.

Step Three

Wait for application results

In 1-2 days you'll receive an email from **support@omadahealth.com** with information regarding your application. If you haven't received an email notification after a couple of days, be sure to check your inbox and spam folder for the message. If at any point in the process you have questions about the status of your application, you can email or call Omada for assistance.

Step Four

Create account

If Omada accepts your application, the email will provide instructions for setting up your Omada account online so you can begin to participate in the program.

- You can set up your account on your own time. There is no strict deadline, but the sooner you set up, the sooner you can start.
- Within 1-2 weeks of completing account setup, you will receive a welcome kit in the mail that includes your wireless scale.
- The program kicks off each Sunday. Kickoff entails an introductory online message from your coach, the first lesson is *unlocked*, and access to the group message board is opened. Please be advised that Omada may choose not to kick off a new group of participants on the Sundays before or after major U.S. holidays when those holidays may interfere significantly with shipping or group momentum.

Step Five

Participate in the program

Once you've set up your account and your participation has been kicked off, Omada will guide you through the program, which can typically last a year – or more – if necessary. The program starts with a core 16-week **Foundations phase**, organized into four areas:

- Changing Food Habits
- Increasing Activity Levels
- Preparing for Challenges
- Reinforcing Healthy Choices

You'll then enter the **Focus phase** for the remainder of the first year (and thereafter, if applicable) to continue building healthy habits. All the tools that are provided by Omada during the program are meant for you to keep.

cost to participate

Chevron currently pays the full cost for the Diabetes Prevention Program. There is no fee for eligible employees to take the initial confidential online risk screener. In addition, there is no fee for eligible employees who subsequently enroll and participate in the Diabetes Prevention Program.

when participation starts

If you meet the program's eligibility requirements, you can take the initial **confidential online risk screener** starting on your hire date or on the date you first become eligible, whichever comes first. Access to the risk screener is automatic; enrollment is not required.

Your participation in the **Diabetes Prevention Program** starts when your online application is accepted by Omada and you create your personal Omada account online.

when participation ends

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

- You are no longer eligible. Participation ends on the last day of the month that eligibility ends.
- If you are currently enrolled and participating in the program, Omada may remove you from enrollment in the Diabetes Prevention Program at any time if, in its sole discretion, Omada believes that the circumstances of your enrollment may put your health or safety at risk.
- Chevron Corporation terminates the Omnibus Health Care Plan or a particular wellness program offered under the plan.
- After 31 days of the following types of leave:
  - Personal Leave Without Pay.
  - Leave for educational reasons.
  - Long Union Business Leave (unless you elect to pay 100% of the cost of continued health coverage).

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

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

confidentiality

The Omada Program complies with the Privacy, Security and Breach Notification rules of the Health Insurance Portability and Accountability Act (HIPAA). You can find their Privacy Policy at **www.omadahealth.com/privacy-policy**.

Omada will not share your confidential online risk screener and application responses, medical information or the contents of your Omada participation with anyone at your health plan unless you specifically authorize such disclosure.

Chevron has authorized Omada to contact eligible employees to invite them to use the program's services and resources. You can opt out of Omada communications if you choose.

Peer group members participating in the Omada program can see:

- Each other's photo, should a member choose to share it.
- First name, should a member choose to share it.
- Introduction note, should a member choose to provide one.

Concerning progress through the program, others in the group can see each other's lesson completion progress, and a progress bar that measures weight loss as a percentage without sharing actual weight. No one in the group will be able to see a participant's private information such as weight or last name. You are not required to participate in the peer group to participate in the Diabetes Prevention Program.

how to file a claim for eligibility

This section describes how to dispute decisions regarding your eligibility to participate in Chevron's wellness programs.

One of the requirements to participate in Chevron's wellness programs is that you must be eligible to participate in the **Omnibus Health Care Plan**. 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
Department: CVXH
P.O. Box 981901
El Paso, TX 79998

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 for Eligibility

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
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 or by calling the HR Service Center:

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

Chevron Corporation Omnibus Health Care Plan
Plan number: 560 **Type of Administration:** Contract Administration **Type of Plan:** Health Plan

Chevron Corporation Omnibus Health Care Plan - Wellness Program: Healthy You
Plan number: 560 **Claims Administrator/Insurer:** WebMD **Type of Administration:** Contract Administration **Type of Plan:** Welfare Plan

Chevron Corporation Omnibus Health Care Plan - Wellness Program: Health Decision Support
Plan number: 560 **Claims Administrator/Insurer:** 2nd.MD **Type of Administration:** Contract Administration **Type of Plan:** Welfare Plan

Chevron Corporation Omnibus Health Care Plan - Wellness Program: Diabetes Prevention Program
Plan number: 560 **Claims Administrator/Insurer:** Omada Health **Type of Administration:** Contract Administration **Type of Plan:** Welfare 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. 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 health care plans, provided both of the following apply:

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

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

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

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

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

Incorrect Computation of Benefits

If you believe that the amount of the benefit you receive from the plan is incorrect, you should notify the plan 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 administrator will pay according to the terms of the applicable wellness program.

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

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

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 these programs, 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. Benefit 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.

Recovery of Overpayments

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

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

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

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

HIPAA

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

your ERISA rights

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

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

Receive Information About Your Plan and Benefits

You have the right to:

- Examine (without charge) at the plan administrator's office and at other specified locations, such as work sites, all Plan documents. These may include insurance contracts, collective bargaining agreements, official Plan texts, trust agreements and copies of all documents, such as the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain (by writing to the plan administrator) copies of all documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, copies of the latest Form 5500 annual report, and an updated SPD. The plan administrator can make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You have a right to continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. For information regarding your continuation coverage rights, review **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. Additionally, you can mail your request to the HR Service Center.

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

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

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

- If you request a copy of the plan documents or the plan's latest annual report and do not receive them within 30 days, you can file suit in a federal court. In such a case, the court can require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials — unless the materials were not sent because of reasons beyond the control of the plan administrator.
- If you disagree with the plan's decision or lack of response to your request concerning the qualified status of a domestic relations order or medical child support order, you can file suit in a federal court.
- If you have a claim for benefits that is denied or ignored, in whole or in part, you can file suit in a state or federal court (see the **Filing a Lawsuit** 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 don't receive a timely written denial of the claim, the plan administrator reserves the right to contend that you may still not file a legal action until you file a timely written request for a review of the denied claim with the appropriate claims administrator and that review is complete. If you want to take legal action after you exhaust the 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 also can serve process on a plan by serving the plan administrator. If you have a dispute with a health maintenance organization (HMO) or dental health maintenance organization (DHMO) regarding benefits or claims, then any legal action should be directed to the agent for service of legal process appointed by the HMO or DHMO. The plan administrator is the appropriate party to sue for all Chevron Corporation benefit plans.

other legislation that can affect your benefits

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

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

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

Notice Regarding Wellness Programs

If you choose to participate in the Chevron wellness programs highlighted in this summary plan description, review the **Notice Regarding Wellness Programs** available from the **Legal Notices** section on **hr2.chevron.com** to learn about employee health information that may be collected, how it will be used, who will receive it, and what will be done to keep it confidential.

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.

COBRA and continuation 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.

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

who's eligible for continuation coverage

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

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

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

qualifying events

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

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

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

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

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

Special Rule for Bankruptcy of the Employer

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

Chevron Must Give Notice of Some Events

Chevron has the responsibility to notify the COBRA coverage administrator – currently, BenefitConnect | COBRA – when any of the following occurs:

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

You Must Give Notice of Some Events

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

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

The following information should be included in the notice:

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

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

You should provide your notice to the Chevron HR Service Center. Additionally, you can mail your notice to the HR Service Center.

If you or a family member does not provide this notice to Chevron's HR Service Center within the time limit specified above, you and your dependents will lose eligibility for continuation coverage with respect to that qualifying event.

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

Electing Continuation Coverage

When the COBRA administrator is notified that one of these events has occurred, the COBRA administrator will in turn notify you that you have the right to elect continuation coverage. Under the law, you have 60 days from the date you would lose Chevron health plan coverage because of one of these events, or the date your continuation coverage election notice is sent to you, whichever is later, to inform the COBRA administrator that you want continuation coverage.

Each qualified beneficiary has an independent right to elect continuation coverage. Covered employees can elect continuation coverage on behalf of their spouses/domestic partners, and parents can elect continuation coverage on behalf of their dependent children.

You or your eligible dependents must complete and return the continuation coverage election form within 60 days after Chevron health plan coverage would otherwise end or, if later, within 60 days after the date your continuation coverage election notice is sent to you. If you do not choose continuation coverage during the election period, your Chevron health plan coverage will end the last day of the month in which your employment ends.

If you or your dependent elects continuation coverage within this 60-day period, upon timely receipt of the full amount of the first required premium payment for continuation coverage, your or your dependent's Chevron health plan coverage will be reinstated retroactive to the date Chevron health plan coverage ended.

Keep the Plan Informed of Address Changes

In order to protect your family's rights, you should keep Chevron informed of any changes in the addresses of family members by contacting the HR Service Center and the COBRA administrator. You should also keep a copy, for your records, of any notices you send to the HR Service Center.

how much continuation coverage costs

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

If you or your dependents are eligible for the 11-month disability extension and the disabled qualified beneficiary elects continuation coverage, you or your dependents will pay 150 percent of the cost of health plan coverage that's continued for months 19 through 29.

how to pay for continuation coverage

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

First Payment

Your first payment for continuation coverage is due within 45 days after the date of your election. This is the date the continuation coverage election form is postmarked, if mailed, or the date you completed your online enrollment. Your first COBRA payment covers the period before you make your election, retroactive to your COBRA start date. If you do not make your first premium payment for continued coverage within 45 days, you will lose all continuation coverage rights under the plan. Health claims will not be processed and paid until you have elected COBRA and made the first payment in full.

Ongoing Payments

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

Payment Methods

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

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

Grace Period

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

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

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

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

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

when continuation coverage starts

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

How Long Continuation Coverage Lasts

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

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

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

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

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

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

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

Disability extension of 18-month period of continuation coverage

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

- Your continuation coverage qualifying event was an employee's termination of employment (for any reason other than gross misconduct) or a reduction in hours so that the employee (and you) was no longer eligible for Chevron health care benefits.
- The disability started at some time before the 60th day of continuation coverage and lasts at least until the end of the 18-month period of continuation coverage.
- A copy of the Notice of Award from the Social Security Administration is provided to the HR Service Center within 60 days of receipt of the notice and before the end of the initial 18 months of continuation coverage.
- If the disabled qualified beneficiary elects continuation coverage, you must pay an increased premium of 150 percent of the monthly cost of health plan coverage that's continued, beginning with the 19th month of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

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

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

Extension Due to Medicare Eligibility

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

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

when continuation coverage ends

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

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

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

Important note regarding
Medicare eligibility and COBRA continuation coverage

If you are *already* eligible for Medicare at the time you experience a qualifying event and you choose to enroll in COBRA continuation coverage, you will be permitted to maintain your COBRA coverage for the duration of your eligibility period.

- For example, if you are an eligible employee who is over age 65 and you leave Chevron, you can choose to elect COBRA continuation coverage when you leave. You will be able to maintain that coverage for the duration of your eligibility period – typically 18 months.

If you *first* become eligible for Medicare while you are *already* enrolled COBRA continuation coverage, your COBRA continuation coverage will end. You are not allowed to maintain COBRA coverage for the full duration of the eligibility period in this situation.

- For example, if you are an eligible employee who is under age 65 and you leave Chevron, you can choose to elect COBRA continuation coverage when you leave. However, if you turn age 65 and/or become eligible for Medicare, your COBRA continuation coverage will end, even if you have not reached your maximum eligibility period – typically 18 months.

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 **Who's Eligible to Participate** chapter, **Enrollment Milestones** section and the **COBRA** chapter of the retiree health benefit summary plan descriptions for more information about this enrollment milestone.

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

Thinking about retirement?

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

Special Rule:
Periods of Continuation Coverage Subject to the Uniformed Services Employment and Reemployment Rights Act of 1994

If you are on a Military Service Leave, you will be permitted to continue health plan coverage for you, your spouse and your dependent children in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and pursuant to Chevron policy.

While you are on a Military Service Leave, your health plan coverage may continue. Chevron will continue to pay its normal company contribution, provided that you continue to timely pay your required employee contributions. While you are on paid status, your employee contribution will be deducted from your paycheck, provided that you have sufficient funds available after required deductions. If your employee contribution exceeds the amount of pay available, or if you are on unpaid status, you will receive a bill from Chevron's HR Service Center for your health plan coverage.

It is your responsibility to make timely payments for your regular benefits coverage as defined by the administrative rules of the Omnibus Health Care Plan. If the full premium payment is not received by the payment due date, your regular benefits coverage will be terminated retroactive to the end of the month for which full payment was received. If you have been on Military Service Leave for less than 24 months at the time your regular coverage ends, you will be offered continuation coverage (under USERRA).

Your, your spouse's or your dependent's period of continuation coverage under USERRA will begin on the date your Military Service Leave begins and will end on the earliest of the following dates:

- The 24-month period beginning on the date on which your Military Service Leave begins;
- The period ending on the day after the date on which you fail to timely apply for or return to a position of employment with Chevron, as determined under Section 4312(e) of USERRA.

Periods of continuation coverage offered in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) will run concurrently with periods of continuation coverage offered pursuant to COBRA and Chevron policy.

You are covered under USERRA if you serve voluntarily or involuntarily as a member of the uniformed services of the United States, including serving in the reserves or as designated by the president. The uniformed services include the U.S. Army, Navy, Marines, Air Force and Coast Guard, and the Public Health Service Commissioned Corps.

How Much USERRA Continuation Coverage Costs

If you fail to pay your employee contributions such that you are no longer eligible for regular coverage and you elect USERRA continuation coverage, you must pay 100 percent, plus a 2 percent administrative fee, of the cost of health plan coverage that's continued. The cost of coverage will vary based on the plans you're enrolled in and how many family members are enrolled.

glossary

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.

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.

Corporation
Refers to Chevron Corporation.

Domestic Partner
See the **Eligible Domestic Partner** section in the **Who's Eligible to Participate** chapter of this summary plan description for the definition of an eligible domestic partner.

Eligible Dependent Child
See the **Eligible Children's or Other Dependents** section in the **Overview of the Plan** chapter of this summary plan description for the definition of an eligible dependent child.

Eligible Employee
See the **Eligible Employees** section in the **Who's Eligible to Participate** chapter of this summary plan description for the definition of an eligible employee.

Eligible Spouse
See the **Eligible Spouse** section in the **Who's Eligible to Participate** chapter of this summary plan description for the definition of an eligible spouse.

Health and Welfare Eligibility Service (HWES)
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.

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.

Leased Employee

Someone who provides services to Chevron in a capacity other than that of a common-law employee and who meets the requirements of Section 414(n) of the Internal Revenue Code. This law requires Chevron to treat leased employees as if they're common-law employees for some purposes, but doesn't require that they be eligible for benefits.

Open Enrollment

Typically, open enrollment is held 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.

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.

Professional Intern
An individual who works either a full-time or part-time work schedule and whose work periods with Chevron alternate with school periods.

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

Seasonal Employee
An individual who's hired to work a regular work schedule for a portion of each year on a repetitive basis in a job designated to cover a seasonal operating need.