Group Accidental Death and Dismemberment (AD&D) Certificate of Insurance

Securian Life Insurance Company • A Stock Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

SECURIAN®

Effective January 1, 2024

POLICYHOLDER: Chevron Corporation

POLICY NUMBER: 70593

Read Your Certificate Carefully

If you meet the eligibility and enrollment requirements herein, you are insured under the group policy shown on the specifications page. This certificate summarizes the principal provisions of the group policy that affect you. The provisions summarized in this certificate are subject in every respect to the group policy. You may examine the group policy at the principal office of the policyholder during regular working hours.

Legal Actions

No legal action may be brought to recover on this certificate within the first sixty days after written proof of loss has been given as required by this certificate. No such action may be brought after three years from the time written proof of loss is required to be given.

Renée D. Montz

Secretary

President

TABLE OF CONTENTS

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) CERTIFICATE OF INSURANCE

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

Securian Life Insurance Company
To get information or file a complaint with your insurance company:
Call: Consumer Complaints, toll free at: 1-855-651-3500
Email: ConsumerComplaints@securian.com
Mail: 400 Robert Street North, St. Paul, MN 55101-2098

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:
Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

Securian Life Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros:
Llame a: Consumer Complaints, teléfono gratuito al 1-855-651-3500
Correo electrónico: ConsumerComplaints@securian.com
Dirección postal: 400 Robert Street North, St. Paul, MN 55101-2098

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

Securian Life Insurance Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

SECURIAN®

GENERAL INFORMATION

POLICYHOLDER Chevron Corporation

POLICY NUMBER: 70593

ASSOCIATED COMPANIES: All subsidiaries and affiliates reported to Securian Life by the policyholder for inclusion in the policy.

POLICY SITUS: The policy was issued and delivered in Texas.

POLICY EFFECTIVE DATE: January 1, 2024.

This certificate and/or certificate specifications page replaces any and all certificates and/or certificate specifications pages previously issued to you under the group policy. Please replace any certificate and/or certificate specifications page previously issued to you with this new certificate and/or specifications page.

GROUP: The group is composed of all active employees of the policyholder and its associated companies working in the United States in the following classes:

Class 1 All Employees on U.S. payroll and determined to be benefit eligible by the employer.

Class 3 All Retirees who pay retiree rate table 2 (2-1, 2-2, 2-3) Closed Class

All new employees of the employer will be added to such group and classes for which they become eligible.

NO DOUBLE COVERAGE: A person cannot be covered under more than one class. A person cannot be covered as both an active employee and a retiree. Any person who is eligible as an employee/retiree and a dependent can only be covered as either the employee/retiree or the dependent, double coverage is not allowed. Only one person can insure an eligible dependent child.

WAITING PERIOD: None

MINIMUM HOURS PER WEEK REQUIRED: 30 hours per week (applies to Class 1 only)

PLAN OF INSURANCE

EMPLOYEE BENEFIT SCHEDULE

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE:

Eligible Class	Amount of AD&D Insurance
Class 1	One, two three, four, five, six, seven or eight times annual earnings, rounded to the next higher $5,000, subject to a minimum of $20,000 and a maximum of $1,000,000.

Class 3	An amount elected by the Retiree from the following options: $10,000, $20,000, $30,000

GENERAL PROVISIONS FOR EMPLOYEE INSURANCE

AGE REDUCTIONS: None

RETIREMENT REDUCTIONS (applies to Class 1 only): All insurance terminates at retirement.

CONTRIBUTORY/NONCONTRIBUTORY: All AD&D insurance is contributory insurance.

INCREASES AND DECREASES: The effective date of increases and decreases due to a change in eligible class or earnings is the date of the change in eligible class or earnings. All increases are subject to the actively at work requirement.

Requests for increases and decreases may be made only at annual enrollment or within 31 days of a qualified status change (as defined by the employer). Requests made due to a status change shall be effective on the date of the request. Requests made during an annual enrollment shall be effective on the general effective date of the annual enrollment. All increases are subject to the actively at work requirement.

DEPENDENTS BENEFIT SCHEDULE

DEPENDENTS AD&D INSURANCE:

The amount of Dependent's AD&D insurance is based on the composition of the employee's family as follows:

Eligible Class	Amount of AD&D Insurance
Class 1	With Eligible Spouse/Domestic Partner and Children: Spouse/Domestic Partner: 50% of employee's amount of insurance* Each Child: 20% of employee's amount of insurance* With Eligible Spouse/Domestic Partner Only Spouse/Domestic Partner: 60% of employee's amount of insurance* With Eligible Children Only: Each Child: 30% of employee's amount of insurance*
Class 3	With Eligible Spouse/Domestic Partner and Children: Spouse/Domestic Partner: 20% of employee's amount of insurance* Each Child: 5% of employee's amount of insurance* With Eligible Spouse/Domestic Partner Only: Spouse/Domestic Partner: 30% of employee's amount of insurance* With Eligible Children Only: Each Child: 15% of employee's amount of insurance*

* The maximum benefit for spouse/domestic partner/child coverage is as follows:
Class 1: $600,000 Spouse/Domestic Partner and $300,000 for child.
Class 3: $9,000 for spouse/domestic partner and $4,500 for child

GENERAL PROVISIONS FOR DEPENDENTS INSURANCE

CONTRIBUTORY/NONCONTRIBUTORY: Dependents insurance is contributory insurance.

INCREASES AND DECREASES: Dependents insurance shall automatically increase or decrease as the employee's amount of insurance increases or decreases.

ADDITIONAL INFORMATION

OPEN ENROLLEMNT The employer will hold an open enrollment prior to the policy effective date. During this enrollment all employees currently enrolled in this coverage need to re-enroll. If no action is taken the VGAI (VAD&D) coverage will terminate. Any employee not currently enrolled in VGAI (VAD&D) can elect any coverage level.

Definitions

associated company

Any company which is a subsidiary or affiliate of the policyholder which is designated by the policyholder and agreed to by us to participate under the group policy.

contributory insurance

Insurance for which the employee is required to make premium contributions.

earnings

Your regular pay determined on an annualized basis as follows: If your regular pay is an annual salary, such annual salary amount will be your annualized regular pay (earnings). If your regular pay is paid on a weekly or hourly basis, your annualized regular pay (earnings) will be determined by multiplying your base rate of pay by the annual number of weeks or hours in your regular work schedule as determined by the Corporation. In general, regular pay includes pay received while on a paid leave of absence and any before-tax contributions to benefit plans but not the premium portion of overtime pay, shift differentials, special payments (bonuses or incentives), commissions, or any pay you may receive for work you do outside of your regular schedule.

employee

An individual who is employed by the policyholder or by an associated company. A sole proprietor will be considered the employee of the proprietorship. A partner in a partnership will be considered an employee so long as the partner's principal work is the conduct of the partnership's business. The term employee does not include temporary employees nor corporate directors who are not otherwise employees.

employer

The policyholder or any designated associated company.

insured

A person who is eligible for and becomes insured under the terms of this certificate.

licensed physician

An individual who is licensed to practice medicine or treat illness in the state in which treatment is received. The physician cannot be you or your spouse, children, parents, grandparents, grandchildren, brothers or sisters, or the spouse of any such individuals.

non-work day

A day on which the employee is not regularly scheduled to work, including scheduled time off for vacations, personal holidays, weekends and holidays, and approved leaves of absence for non-medical reasons.

Non-work day does not include time off for medical leave of absence, temporary layoff, employer suspension of operations in total or in part, strike, and any time off due to sickness or injury including sick days, short-term disability, or long-term disability.

noncontributory insurance

Insurance for which the employee is not required to make premium contributions.

policyholder

The owner of the group policy as shown on the specifications page.

specifications page

The outline which summarizes your coverage under the policyholder's plan of insurance.

waiting period

The period, if any, of continuous employment with the employer that the employee must satisfy prior to becoming eligible for coverage under this certificate. You are not eligible to become insured until the first day following the waiting period. Any such waiting period is shown on the specifications page .

we, our, us

Securian Life Insurance Company.

you, your, certificate holder

An insured employee.

General Information

What is your agreement with us?

If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application as defined under this certificate is a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

Any statements made in your application as defined in this certificate will, in the absence of fraud, be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless the statement is contained in the application.

Can this certificate be amended?

Yes. We retain the right to amend this certificate at any time without your consent. Any amendment will be without prejudice to any claim incurred for benefits prior to the date of the amendment.

What employees are eligible for Accidental Death and Dismemberment (AD&D) insurance?

An employee is eligible for AD&D insurance if he or she:

(1) is a member of the eligible group and of an eligible class identified in the group policy; and
(2) works for the employer for at least the number of hours per week shown as the minimum hours per week requirement on the specifications page; and
(3) has satisfied the waiting period, if any; and
(4) meets the actively at work requirement described in the "What is the actively at work requirement?" provision of this section.

What dependents are eligible for AD&D insurance under this certificate?

The following members of your family are eligible for AD&D insurance under this certificate:

(1) your lawful spouse who is not legally separated from you; or
(2) your domestic partner who meets and continues to meet all of the criteria detailed in Chevron's Affidavit of Domestic Partnership and the Domestic Partnership has been internally registered with the Corporation by filing an original, properly completed, notarized Chevron Affidavit of Domestic Partnership that has been accepted by the Corporation; and
(3) your or your spouse/domestic partner's natural, legally adopted or stepchildren who are less than 26 years old. An adopted child includes a child legally placed for adoption with you. Eligibility begins at live birth (stillborn or unborn children are not eligible).

A person who is eligible as an employee or retiree under the policy, or insured under the portability provisions, is not eligible as a dependent. Only one person can insure an eligible dependent child.

Are employees of associated companies eligible for insurance under the group policy?

Yes. Employees of associated companies may be eligible for insurance under the group policy. The policyholder represents any associated company in all transactions pertaining to the group policy. The policyholder's acts or omissions and every notice given by us to the policyholder shall be binding on every associated company. When an associated company ceases its participation under the policy, the policy shall be considered to be terminated for all employees of the associated company. All provisions related to the policy terminating will apply to such employees.

Are retired employees eligible for insurance?

If the policyholder's plan of insurance, as shown on the specifications page, does not specifically provide insurance for retired employees, a retired employee shall not be eligible to become insured, nor to have his or her insurance continued. If the policyholder's plan of insurance specifically provides insurance for retired employees, the minimum hours per week and actively at work requirements will not apply to such persons.

What is the actively at work requirement?

To be eligible to become insured or to receive an increase in the amount of insurance, an employee must be actively at work performing his or her customary duties at the employer's normal place of business, or at other places the employer's business requires him or her to travel.

Employees not working due to illness or injury do not meet the actively at work requirement nor do employees receiving sick pay, short-term disability benefits or long-term disability benefits.

If the employee is not actively at work on the date coverage would otherwise begin, or on the date an increase in his or her amount of insurance would otherwise be effective, he or she will not be eligible for the coverage or increase until he or she returns to active work. However, if the absence is on a non-work day, coverage will not be delayed provided the employee was actively at work on the work day immediately preceding the non-work day.

Except as otherwise provided for in this certificate, an employee is eligible to continue to be insured only while he or she remains actively at work.

Any insurance or increase in insurance which is elected or put in force while you are not actively at work will not be eligible for claim payment. You or your beneficiary will receive a refund of premium for any contributory insurance for which you were not eligible.

When does your insurance become effective?

Your insurance becomes effective on the date that all of the following conditions have been met:

(1) you meet all eligibility requirements; and
(2) for contributory coverage, you apply for coverage in accordance with the application methods agreed upon by the policyholder and us.

When does a dependent's insurance become effective?

Insurance on a dependent becomes effective on the date that all of the following conditions have been met:

(1) your insurance becomes effective;
(2) the dependent meets all eligibility requirements; and
(3) for contributory coverage, you apply for dependents coverage in accordance with the application methods agreed upon by the policyholder and us.

Can your coverage be continued during sickness, injury, leave of absence or temporary layoff?

Yes. Insurance may be continued on an insured employee who is not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to the employer's practices and procedures, including the employer's limits on the length of continuation allowed for the type of absence.

Coverage during a leave of absence and upon return from a leave of absence shall meet all state and federal requirements. The above limits will be expanded if necessary in order to meet such requirements.

Premiums

When and how often are your premium contributions due?

Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a regular periodic basis. We apply premiums consecutively to keep the insurance in force.

How is the premium determined?

The premium will be the applicable premium rate multiplied by the number of $1,000 units of insurance in force on the date premiums are due. The premium may also be computed by any other method on which the policyholder and we agree.

Premium rates are subject to change according to the provisions of the group policy.

Accidental Death and Dismemberment Benefit

What does accidental death or dismemberment by accidental injury mean?

AD&D coverage is limited coverage. This means this coverage will provide benefits only when the insured's loss, death or dismemberment results, directly and independently from all other causes, from an accidental bodily injury which was unintended, unexpected and unforeseen. The bodily injury must be evidenced by a visible contusion or wound, except in the case of accidental drowning. The bodily injury must be the sole cause of the insured's loss, death or dismemberment. The injury and accidental loss, death or dismemberment must occur while the insured's coverage is in force. The insured's loss, death or dismemberment must occur within 365 days after the date of the accidental injury. In no event will we pay the accidental death or dismemberment benefit where the insured's accident, injury, loss, death or dismemberment is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

(1) self-inflicted injury, self-destruction, or autoeroticism, whether sane or insane; or
(2) suicide or attempted suicide, whether sane or insane; or
(3) the insured's participation in, or attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto; or
(4) bodily or mental infirmity, illness or disease; or
(5) the use of alcohol; or
(6) the use of prescription drugs, non-prescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected; or
(7) motor vehicle collision or accident where the insured is the operator of the motor vehicle and the insured's blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
(8) infection, other than infection occurring simultaneously with, and as a direct and independent result of, the accidental injury; or
(9) medical or surgical treatment or diagnostic procedures or any resulting complications, including complications from medical misadventure; or
(10) travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier, or as a passenger, pilot, or crew member on any aircraft that is owned, leased, operated, or controlled by the Policyholder. Such aircraft will be piloted by a properly licensed pilot with appropriate ratings for the aircraft and flight involved and have a current valid airworthiness certificate; or
(11) war or any act of war, whether declared or undeclared.

What is the amount of the AD&D benefit?

The amount of the benefit shall be a percentage of the amount of insurance shown on the specifications page . The percentage is determined by the type of loss as shown in the following table:

TYPE OF LOSS	PERCENT OF AMOUNT OF INSURANCE
Life	100%
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
Speech and Hearing in Both Ears	100%
One Hand and One Foot	100%
One Foot and Sight of One Eye	100%
One Hand and Sight of One Eye	100%
Quadriplegia	100%
Paraplegia	75%
Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
One Hand or One Foot	50%

Hemiplegia..... 50%
All Four Fingers of One Hand..... 50%
Thumb and Index Finger of One Hand..... 25%
Hearing in one Ear……..25%
Uniplegia..... 25%

Loss of hands or feet means complete severance at or above the wrist or ankle joints. Loss of sight, speech, or hearing means the entire and irrecoverable loss of sight, speech, or hearing which cannot be corrected by medical or surgical treatment or by artificial means.

Loss of thumb or finger means complete severance at or above the metacarpophalangeal joints.

Quadriplegia means total and permanent paralysis of both upper limbs (from the shoulder down including total paralysis of both hands) and both lower limbs (from the waist down including total paralysis of both feet). Paraplegia means total and permanent paralysis of both lower limbs (from the waist down including total paralysis of both feet). Hemiplegia means total and permanent paralysis of both the upper limb (from the shoulder down including total paralysis of the hand) and lower limb (from the waist down including total paralysis of the foot) on one side of the body. Uniplegia means total and permanent paralysis of one limb (from the shoulder down including total paralysis of the hand if claiming an upper limb and from the waist down including total paralysis of the foot if claiming a lower limb).

A benefit is not payable for both loss of one hand and the loss of thumb and index finger of one hand for injury to the same hand as a result of any one accident (the largest benefit of these overlapping losses only will be paid). Under no circumstance will more than one payment be made for the loss or paralysis of the same limb, eye, finger, thumb, hand, foot, sight, speech, or hearing if one payment has already been made for that loss.

Benefits may be paid for more than one accidental loss but the total amount of AD&D insurance payable under this certificate for any one accident, not including any amount paid according to the terms of the Additional Benefits section of this certificate, will never exceed the full amount of the insured's AD&D insurance.

Can you request a change in the amount of your contributory insurance?

Yes. The specifications page describes when changes can be requested, when evidence of insurability will be required for such changes, and when the changes will become effective.

What are the notice of claim and proof of loss requirements?

Written notice of injury on which a claim may be based must be given to us within 30 days after the accident. Proof of loss must be furnished to us within 90 days after the date of loss. However, failure to give such notice and proof within the time provided will not invalidate the claim if it is shown that notice and proof were given as soon as reasonably possible.

When we receive written notice of claim, we will send the claimant our claim forms if he or she needs them. If the claimant does not receive the forms within 15 days, we will accept his or her written description as proof of loss.

When will the accidental death or dismemberment benefit be payable?

We will pay the accidental death or dismemberment benefit upon receipt at our home office of written proof satisfactory to us as to both substance and form that you died or suffered a covered dismemberment as a result of a covered accidental injury. All payments by us are payable from our home office. The benefit will be paid in a single sum.

To whom will we pay the accidental death or dismemberment benefit?

In the case of your accidental death, we will pay the accidental death benefit to the beneficiary or beneficiaries. All other benefits,including any accidental death or dismemberment payable due to a dependent's loss, will be payable to you, if living, otherwise to your estate.

You name a beneficiary to receive the death benefit to be paid at your death. You may name one or more beneficiaries. You can change the beneficiary designation at any time, provided all of the following are true:

(1) your coverage is in force; and
(2) we have written consent of all irrevocable beneficiaries; and
(3) you have not assigned the ownership of your insurance.

A beneficiary designation must be made in writing or by any other method made available under the plan. Any beneficiary designation shall take effect as of the date it is signed, but will not affect any payment we make or action we take before receiving the designation.

You may also choose to name a beneficiary that you cannot change without the beneficiary's consent. This is called an irrevocable beneficiary.

If there is more than one beneficiary, each will receive an equal share, unless you have requested another method in your beneficiary designation. To receive the death benefit, a beneficiary must be living at the time of your death. In the event a beneficiary is not living at the time of your death, that beneficiary's portion of the death benefit shall be equally distributed to the remaining surviving beneficiaries. In the event of the simultaneous deaths of you and a beneficiary, the death benefit will be paid as if you survived the beneficiary.

If there is no eligible beneficiary, or if you do not name one, we will pay the death benefit to:

(1) your lawful spouse or domestic partner, as applicable, if living; otherwise
(2) your or your spouse/domestic partner's natural or legally adopted child (children) in equal shares, if living; otherwise
(3) your parents in equal shares, if living; otherwise
(4) your natural or legally adopted siblings in equal shares, if living; otherwise
(5) the personal representative of your estate.

Additional Benefits

Unless stated otherwise, additional benefits are payable to the same person or persons who receive the AD&D benefits. Additional benefits are paid in addition to any AD&D benefits described in the Accidental Death and Dismemberment section, unless otherwise stated.

All provisions of this certificate, including but not limited to the exclusions and requirements listed under the "What does accidental death or dismemberment by accidental injury mean?" section, shall apply to these additional benefits**.**

Air Bag Benefit

What is the air bag benefit?

If an insured dies or suffers a covered dismemberment as a result of a covered accident which occurs while he or she is driving or riding in a private passenger car, we will pay an additional AD&D benefit equal to the lesser of:

(1) $25,000; or
(2) 25% of the insured's amount of AD&D insurance.

In order to be eligible for this benefit, the following must apply:

(1) the seat in which the insured was seated was equipped with a properly installed airbag at the time of the accident; and
(2) the private passenger car is equipped with seatbelts; and
(3) a seatbelt was in proper use by the insured at the time of the accident as certified in the official accident report or by the investigating officer; and
(4) at the time of the accident, the driver of the private passenger car was a licensed driver and was not intoxicated, impaired, or under the influence of alcohol or drugs.

Airbag means a passive restraint device in a vehicle which inflates upon collision to protect an individual from injury or death.

Seatbelt means a properly installed seatbelt (or child restraint if the insured is a child), lap and shoulder restraint, or other restraint approved by the National Highway Traffic Safety Administration or any successor governmental agency. A private passenger car means a validly registered four-wheeled private passenger car or policyholder-owned car, jeep, pickup truck or van, including a sport utility vehicle (SUV), that is not licensed commercially or being used for racing, or acrobatic or stunt driving.

Brain Damage Benefit

What is the brain damage benefit?

If an insured sustains and is diagnosed by a licensed physician as having Traumatic Brain Injury (TBI) as a result of and within 365 days of a covered accidental injury, and such TBI damage has lasted for a minimum of 12 consecutive months, we will pay a monthly benefit equal to the lesser of:

(1) 1% of the insured's amount of AD&D insurance; or
(2) 1% of the difference between the insured's amount of AD&D insurance and the amount of any benefits paid under the loss schedule for the same accident (if the full amount of AD&D insurance has been paid, no benefit is payable under this section).

The insured must be hospitalized due to TBI for at least seven days within the first 365 days following the accident. This benefit will be paid monthly until the earlier of the following:

(1) the date of the insured's death. If an accidental death payment is due under this certificate, the amount of such payment will be reduced by the amount of AD&D insurance paid under this brain damage benefit; or
(2) 100 monthly benefits have been paid.

Child Care Benefit

What is the child care benefit?

If you or your insured spouse/domestic partner die as a result of a covered accident and you or your spouse/domestic partner are survived by one or more insured dependent children under age 13, we will pay additional benefits to reimburse for child care expenses incurred for your or your spouse/domestic partner's dependent children while under age 13.

The benefit for each child per year will be the lesser of:

(1) 25% of your amount of AD&D insurance; or
(2) $10,000; or
(3) actual incurred child care expenses.

Child care expenses are those expenses which are for a service or supply furnished by a licensed child care provider or facility for a dependent child's care. No payment will be made for expenses incurred more than four years after the date of your death or for expenses incurred for dependent children over age 13. Proof of incurred child care expenses shall be required before any benefit payment is made.

The child care benefit will be paid to the surviving parent, to the child's guardian, the custodian under the Uniform Transfers to Minors Act or to an adult caretaker when permitted under state law.

Child Dismemberment Double Benefit

What is the child dismemberment double benefit?

If an insured dependent child suffers a covered loss, other than loss of life, the amount payable shall be twice the amount listed in the table found in the "What is the amount of the AD&D benefit?" section of this certificate.

Coma Benefit

What is the coma benefit?

If an insured lapses into a coma as a result of and within 365 days of a covered accidental injury, and such coma has lasted for a minimum of 31 days, we will pay a monthly benefit equal to the lesser of:

(1) 1% of the insured's amount of AD&D insurance; or
(2) 1% of the difference between the insured's amount of AD&D insurance and the amount of any benefits paid under the loss schedule for the same accident. (if the full amount of AD&D insurance has been paid, no benefit is payable under this section).

This benefit will be paid monthly until the earliest of the following:

(1) the date the insured recovers such that he or she is no longer in a coma as defined herein; or
(2) the date of the insured's death. If an accidental death payment is due under this certificate, the amount of such payment will be reduced by the amount of AD&D insurance paid under this coma provision; or
(3) 100 monthly benefits have been paid.

Coma means a state of profound unconsciousness with no evidence of appropriate responses to stimulation. The insured must be confined in a medical facility and diagnosed as comatose by a licensed physician.

Common Accident Benefit

What is the common accident benefit?

If both you and your insured spouse/domestic partner die from covered accidental injuries sustained in a common accident, your spouse/domestic partner's accidental death benefit will be increased to an amount equal to 100% of your amount of AD&D insurance.

Common accident means the same accident or separate accidents that occur within the same 24-hour period. You and your insured spouse must also die within 365 days of each other from the common accident.

Dependent Child Education Benefit

What is the dependent child education benefit?

We will pay an education benefit on behalf of your or your insured spouse/domestic partner's dependent children if the insured dies as a result of a covered accident and are survived by one or more insured dependent children, provided that:

(1) at the time of your death, the dependent child is enrolled as a full-time student at an accredited post-secondary educational institution (however, no benefit will be payable for the current school year); or
(2) the dependent child enrolls on a full-time basis in an accredited post-secondary educational institution within one year of your death.

The benefit payable will be the lesser of:

(1) the actual tuition charged, exclusive of room and board; or
(2) 25% of your amount of insurance; or
(3) $25,000.

The benefit will be payable at the beginning of each school year for a maximum of four consecutive years, but not beyond the date the child attains age 25. The benefit will be paid to the insured dependent child if he or she is of legal age. If the insured dependent child is not of legal age the benefit will be paid to the person who provides proof they have paid or will pay the tuition bill for that school year. Proof of enrollment and tuition costs are required for each school year.

Disappearance Benefit

What is the disappearance benefit?

If an insured's body has not been found after one year from the date the conveyance in which he or she was traveling disappeared, exploded, sank, became stranded, made a forced landing or was wrecked, it shall be presumed, subject to all other terms of the policy and proof satisfactory to us that the accident occurred and the insured was a passenger on the conveyance, that the insured has died as a result of an accidental injury which was unintended, unexpected and unforeseen. Such death shall be considered a covered loss under this certificate.

Exposure Benefit

What is the exposure benefit?

If an insured suffers a loss under the Type of Loss schedule due to exposure to the elements, it will be covered as if it were due to injury, provided such loss results from unavoidable exposure to the elements by reason of a covered accident.

Seatbelt Benefit

What is the seatbelt benefit?

If an insured dies or suffers a covered dismemberment as a result of a covered accident which occurs while he or she is driving or riding in a private passenger car, we will pay an additional AD&D benefit equal to the lesser of:

(1) $50,000; or
(2) 25% of the insured's amount of AD&D insurance.

In order to be eligible for this benefit, the following must apply:

(1) the private passenger car was equipped with seatbelts; and
(2) a seatbelt was in proper use by the insured at the time of the accident as certified in the official accident report or by the investigating officer; and
(3) at the time of the accident, the driver of the private passenger car was a licensed driver and was not intoxicated, impaired, or under the influence of alcohol or drugs.

Seatbelt means a properly installed seatbelt (or child restraint if the insured is a child), lap and shoulder restraint, or other restraint approved by the National Highway Traffic Safety Administration or any successor governmental agency. A private passenger car means a validly registered four-wheeled private passenger car or policyholder-owned car, jeep, pickup truck or van, including a sport utility vehicle (SUV), that is not licensed commercially or being used for racing, or acrobatic or stunt driving.

Spouse Education Benefit

What is the spouse education benefit?

We will pay an education benefit on behalf of your spouse/domestic partner if you die as a result of a covered accident and are survived by your insured spouse/domestic partner, provided that your spouse/domestic partner enrolls in a program of higher education within 24 months after your death.

The benefit payable will be the least of:

(1) the actual tuition charged for all such education; or
(2) 25% of your amount of AD&D insurance; or
(3) $25,000.

Only expenses occurring within 36 months after the date of your death will be eligible for reimbursement.

Termination

When does an insured's insurance end?

An insured's insurance ends on the earliest of the following:

(1) the date the group policy ends; or
(2) the date the insured no longer meets the eligibility requirements; or
(3) the date the group policy is amended so the insured is no longer eligible; or
(4) 60 days (the grace period) after the due date of any unpaid premium if the premium remains unpaid at that time; or
(5) the last day for which premium contributions have been paid following your written request to cease participation under this certificate.

When does the group policy terminate?

The policyholder may terminate the group policy by giving us 60 days prior written notice. We reserve the right to terminate the group policy on the earlier of the following to occur:

(1) 60 days (the grace period) after the due date of any premiums which are not paid; or
(2) 60 days after we provide the policyholder with notice of our intent to terminate the group policy.

Additional Information

Do we have the right to obtain independent medical verification?

Yes. After you have provided proof of loss at your expense, we retain the right to have an insured medically examined at our expense whenever a claim is pending.

What if an insured's age has been misstated?

If an insured's age has been misstated, the accidental death or dismemberment benefit payable will be that amount to which the insured is entitled based on his or her correct age.

A premium adjustment will be made to the premium you pay for the insured's noncontributory insurance and to the premium an insured pays for contributory insurance, if any, so that the actual premium required at the insured's correct age is paid. If the insured's correct age is such that no benefit is payable, only a refund of premium will be made for the period the insured was not eligible.

Who is the owner of this coverage?

Unless assigned otherwise, you, the insured employee, are the owner of all coverage provided under your certificate. Only the owner has the right to exercise ownership rights under the certificate, including but not limited to naming or changing a beneficiary, changing the amount of insurance, assigning any or all ownership rights, and terminating the coverage.

Can your insurance be assigned?

Yes. However, we will not be bound by an assignment of the certificate or of any interest in it unless it is made as a written instrument, and you file the original instrument or a

certified copy with us at our home office, and we send you an acknowledged copy.

We are not responsible for the validity of any assignment. You are responsible for ensuring that the assignment is legal in your state and that it accomplishes your intended goals. If a claim is based on an assignment, we may require proof of interest of the claimant. A valid assignment will take precedence over any claim of a beneficiary.

Can a change in ownership for a certificate be requested?

Yes. A change in ownership is a type of assignment. All provisions for assignments apply to ownership changes.

Is the policyholder required to maintain records?

Yes. The policyholder is required to maintain adequate records of any information necessary for us to administer the group policy, and shall provide access to such records when required for us to administer the policy.

If an administrative or clerical error is made in keeping records on or administering the insurance under the group policy, it will not affect otherwise valid insurance. A clerical or administrative error, however, does not continue insurance which is otherwise stopped, make insurance effective when it should not have been or change the amount of insurance provided by the provisions of the policy and no claim shall be paid on amounts put into effect as a result of a past clerical or administrative error. If an error causes a change in premium payment, a fair adjustment will be made.

Can insurance coverage be contested?

Yes. If an insured dies or sustains a covered loss under this certificate within two years of his or her original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided by the insured during the application process. If we discover a material misrepresentation, the coverage will be rescinded and an otherwise valid claim will be denied. This two year period can be extended for fraud or as otherwise allowed by law.

Any statements the insured makes in his or her application will, in the absence of fraud, be considered representations and not warranties. Also, any statement an insured makes will not be used to void his or her insurance, or defend against a claim, unless the statement is contained in the application.

Will the provisions of this certificate conform with state law?

Yes. If any provision in this certificate or in the group policy is in conflict with the laws of the state governing the group policy or the certificates, the provision will be deemed to be amended to conform to such laws.

What is the policy interpretation right and authority?

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

Securian Life has the exclusive right and authority, in its sole discretion, to interpret the group policy and decide all matters arising thereunder. Securian Life's exercise of that authority shall be conclusive and binding on all persons unless it can be shown that the determination was arbitrary and capricious.

Group Accidental Death & Dismemberment Insurance
Certificate Endorsement

Securian Life Insurance Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

SECURIAN®

This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 70593, issued by Securian Life Insurance Company to Chevron Corporation. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to all employees:

1. The following notice is added to the face page of the certificate:

   THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

2. The provision entitled "**What dependents are eligible for AD&D insurance under this certificate?**" under the **General Information** section is amended in its entirety and replaced with the following:

   What dependents are eligible for insurance under this certificate?

   The following members of your family are eligible for AD&D insurance under this certificate:

   (1) your lawful spouse, as recognized under the laws of the jurisdiction of celebration; or
   (2) your domestic partner who meets and continues to meet all of the criteria detailed in Chevron's Affidavit of Domestic Partnership and the Domestic Partnership has been internally registered with the Corporation by filing an original, properly completed, notarized Chevron Affidavit of Domestic Partnership that has been accepted by the Corporation; and
   (3) your or your spouse/domestic partner's natural, legally adopted, stepchild, a child for whom you or your spouse are legal guardians for, or grandchild who is less than 26 years old. A child is considered to be your child if you are a party to a suit in which you seek to adopt the child. An adopted child includes a child legally placed for adoption with you. A covered grandchild must be unmarried and be dependent on you for federal income tax purposes at the time of application for coverage. Eligibility begins at live birth (stillborn or unborn children are not eligible).

   Coverage for a child that reaches age 26 does not terminate while the child continues to be both:

   (1) incapable of self-sustaining employment by reason of a mental retardation or physical disability; and
   (2) chiefly dependent on you for support and maintenance.

   A person who is eligible as an employee or retiree under the policy, is not eligible as a dependent. Only one person can insure an eligible dependent child.

3. The following provision is added to the **General Information** section of the certificate:

   Can an insured's coverage be continued during the employee's work stoppage due to a labor dispute?

   Yes. Insurance may be continued on an insured employee, his or her insured spouse, if any, and/or his or her insured children, if any, if the employee stops work because of a labor dispute. The insured's coverage continues under this certificate if the employee: 1) is covered under this certificate on the date the work stoppage begins; 2) continues to pay the employee's individual contribution; and 3) assumes and pays during the work stoppage the contribution due from the employer. The employee's individual contribution is based on the premium rate applicable to an individual in the class to which the employee belongs on the date the work stoppage begins. Insurance will be deemed to continue until terminated by discontinuance of premium payments, written request or any other applicable termination provisions of this certificate.

   This provision does not limit our right to change premium rates before, during, or after a work stoppage if we would be entitled to change the premium rate had a work stoppage not occurred.

4. The following provision is added to the **Accidental Death and Dismemberment Benefit** section of the certificate:

   When will notice of acceptance or rejection of claim be provided?

   We will notify the claimant in writing of the acceptance or rejection of claim within 15 business days after we receive all items, statements and forms required to secure final proof of loss. If we are not able to accept or reject the claim within this 15 day period we will notify the claimant of the reasons why we need additional time. We shall accept or reject the claim no later than 45 days after the claimant is notified of the need for additional time. If we reject a claim we will provide the claimant with the reason for the rejection.

Renée D. Montz
Secretary

President

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.
- **Life insurance**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.
- **Individual annuities:** Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:

Texas Life and Health Insurance Guaranty Association
1717 West 6th Street, Suite 230
Austin, Texas 78703-4776
1-800-982-6362 or www.txlifega.org

For questions about insurance, contact:

Texas Department of Insurance
PO Box 12030
Austin, Texas 78711
1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

Your Rights Under ERISA

The following section contains information provided to you by the Plan Administrator, to meet the requirements of the Employee Retirement Income Security Act of 1974 (ERISA) for the Plans identified below in which you are enrolled. It does not constitute a part of the insurance policy issued in connection with the Plan. All inquiries relating to the following material should be referred directly to your Plan Administrator. This information should be attached to your certificate of insurance. Along with any document designated by the Plan Administrator as the applicable Summary Plan Description ("SPD") or a component of such SPD, these documents together comprise your Summary Plan Description (SPD) for the Plan(s) identified below in which you or your eligible dependent(s) participate. All documents for the Plans below are available for examination by participants who follow the procedures outlined under the Statement of ERISA Rights.

Summary Plan Description

General Information

Name of Plan to which this certificate of insurance applies and Plan Number	Chevron Voluntary Group Accident Insurance Plan - 855
Plan Sponsor	Name: Chevron Corporation Address: P.O. Box 6075 San Ramon, CA 94583-0767 1-888-825-5247 (610-669-8595 for outside the U.S.)
Employer ID	Employer Identification Number (EIN): 94-0890210
Type of Plan	Welfare Plan providing accident insurance to eligible employees and their eligible dependents.
Administration of Plan	Chevron Corporation has the discretionary authority to control and manage the operation and administration of the above 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. Chevron Corporation administers the benefits under the Plan through an insurance policy and riders purchased from Securian Life Insurance Company, herein known as the "Insurer", 400 Robert Street North, St. Paul, MN 55101, and has thereby delegated the discretionary authority to administer the Plan to Insurer. Insurer has been delegated the full and exclusive discretionary authority to interpret the policy and riders and decide all matters arising thereunder and is the "named fiduciary" for the purpose of determining benefit claims and appeals. Benefit claim and appeal decisions and factual determinations made by the Insurer shall be final and binding on all persons and shall be given full force and effect. The Plan Administrator has retained all other discretionary authority to administer and interpret the Plan including, but not limited to, the determination of eligibility and entitlement to Plan benefits. Any such interpretation or determination by the Plan Administrator shall be final and binding on all persons and shall be given full force and effect. .
Plan Administrator	Chevron Corporation P.O. Box 6075

	San Ramon, CA 94583-0767 1-888-825-5247 (610-669-8595 for outside the U.S.)
Claims Administrator	Securian Life Insurance Company 400 Robert Street North St. Paul, MN 55101-2098
Agent for Service of Legal Process	Any legal process related to the Plans should be served on: Service of Process Chevron Corporation Address: 6001 Bollinger Canyon Road, H1268 San Ramon, CA 94583 Legal process may also be served on the Plan Administrator at P.O. Box 6075 San Ramon, CA 94583-0767.
Plan Year	The plan year for the Plan begins on January 1 and ends on December 31 of each year.
Plan Funding and Source of Contributions	Benefits under the Plan are provided solely under an insurance policy with the Insurer. Insurer has the sole financial responsibility for paying benefits under the policy and the Plan. The premiums for the policy are funded from the general assets of Chevron Corporation. Premiums for the Voluntary Group Accident Insurance Benefit is paid by employees. Premium rates under the insurance policy of the Plan are set by the Insurer.
Recovery of Overpayments	An "overpayment" is any payment made in excess of the amount properly payable under the Plan. Upon any overpayment, the Plan shall have a first right of reimbursement and restitution with an equitable lien by contract in such amount. Furthermore, the holder of such overpayment shall hold it as the Plan's constructive trustee. If you 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 Claims Administrator of the relevant facts. If the 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 Claims Administrator. If the Claims Administrator makes a written demand for the repayment of an overpayment and you (or another person) have not repaid (or cause to be repaid) the overpayment within 30 days following the date on which the demand was mailed, then any amounts subsequently payable as benefits under the Plan with respect to you and/or your covered dependent may be reduced by the amount of the outstanding overpayment, or the Claims Administrator may recover such overpayment by any other appropriate method that the Claims Administrator (or the Plan Administrator) shall determine.
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).
Amendment and Termination	The group policy provides those situations in which the Plan Sponsor or the Insurer has the right to amend or terminate the applicable policy. The Plan Sponsor reserves the right to change or

terminate the Plan, in whole or in part, at any time and for any reason in the Plan Sponsor's sole discretion. A change can also 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, the SPDs and vendor administration at the effective date. In the event of termination, benefits would be discontinued as described in the certificate of insurance.

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 making a written request to the Plan Administrator.

Collective Bargaining Agreements

If a union represents you, you're eligible for the Chevron Voluntary Group Accident Insurance Plan, provided both of the following apply:

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

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

In some cases, 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. A copy of any relevant collective bargaining agreement can be obtained by participants upon written request to their union representatives.

Claim Procedures

Under Department of Labor (DOL) regulations, claimants are entitled to full and fair review of any claims made under the Plan. The procedures described in this section are intended to comply with DOL regulations by providing reasonable procedures governing the filing of benefit claims, notification of benefit decisions, and appeal of adverse benefit decisions.

A. Presenting Claims for Benefits

Claim forms may be obtained by contacting the Insurer.

Contact the plan administrator if you have any questions or to initiate a claim. You may also contact the Insurer directly to initiate a claim. Upon the receipt of notification of a claim the Insurer will provide claim forms. Read the instructions on those forms carefully, and be sure all the questions are answered and that you include any required attachments. Completed forms must be sent to Claims, PO Box 64114, St. Paul, MN 55164-0114. After your claim has been processed by the Insurer, you will be notified in writing if any benefits are denied in whole or in part, or if any additional information is required.

B. Claims Denial Procedure

If all or part of your claim for benefits is denied, the Insurer will notify you in writing within 90 days (45 days for any disability claims) of receiving your claim. If special circumstances require more time, the review period may be extended up to an additional 90 days (30 days for disability claims). You will be notified in writing of this extension within the original review period. The notice of extension will explain the circumstances requiring the extension and indicate the date by which the plan expects to render the benefit determination. For disability claims, the review period may be extended up to an additional 30 days provided the written notice described above is sent to the claimant before the expiration of the first 30-day extension period.

For disability claims, the notice of extension will also include a description of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, the information needed to resolve those issues, and the claimant will be given at least 45 days to provide the information. Where the timeframe to process a disability claim is extended because the claim was incomplete, the time for the claim determination is put on hold from the date the extension notice is sent to the claimant until the date the person responds to the request for additional information. If the person does not provide needed information to the Insurer within 45 days of the date on the notice, the Insurer may deny the claim.

<u>Notification of Claim Denial</u>

Any denial of a claim for benefits will be provided by the Insurer and will include the content required by law.

C. Appealing the Denial of a Claim

You may appeal any denial of a claim for benefits by filing a written request for a full and fair review to the Insurer at Claims, PO Box 64114, St. Paul, MN, 55164-0114. In connection with such a request, documents relevant to the appeal may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. You may have representation throughout the review procedure, if you submit written proof of the representation to the Insurer. An appeal must be filed by 60 days (180 days for disability claims) after receipt of the written notice of denial of a claim. Before the Insurer can deny a claim on appeal, the Insurer shall provide the claimant with any new evidence considered, relied upon, or generated during the appeal, as well as any new rationale for the decision. Any new evidence or rationale will be provided to the claimant free of charge, as soon as possible before the date by which the appeal is to be decided, so that the claimant may respond to the evidence or rationale before that date. The full and fair review will be held and notification of a decision rendered by the Insurer will be provided no later than 60 days (45 days for disability claims) after receipt of the request for review.

If special circumstances beyond the control of the Insurer require more time, the review period may be extended up to an additional 60 days (45 days for disability claims). You will be notified in writing of this extension within the original appeal period. The notice of extension will explain the circumstances requiring the extension and indicate the date by which the Insurer expects to render the benefit determination.

The notice of extension will include a description of any missing information and shall specify a timeframe, no less than 180 days in which the necessary information must be provided. Where the timeframe to process an appeal is extended because additional information to render an appeal decision is needed, the time for the benefit determination is put on hold from the date the extension notice is sent to the claimant until the date the person responds to the request for additional information. If the person does not provide needed information to the Insurer within the 180 days of the date on the notice, the Insurer may close the appeal and no further consideration will take place.

During all steps of the claims appeal procedure, you can write or call the Insurer and ask to see all documents relevant to your claim. In addition, you may have an attorney or other representative write letters or otherwise act on your behalf, but you may need to provide written proof of designation of the representative.

Notification of Appeal Decision

Written notification of the Insurer's decision on an appeal shall be provided to the claimant and will include the information required by law.

D. Legal Action Following Appeals

After completing the claims and appeal procedures, you have the right to dispute the determination by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the Statement of ERISA Rights section for more details. No such action may be filed after two years from the date the Plan gives you a final determination on your appeal or if later, no such action may be brought after three years from the time written proof of the loss is required to be given.. Also, no legal action may be brought if you do not exhaust these claims procedures, unless exhaustion is not required.

Statement of ERISA Rights

The Statement of ERISA rights is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including the insurance contract, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may 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.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

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

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials for the Plan and do not receive them within 30 days, you may file a suit in federal court. In such a case, the court may 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 have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay the cost 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.

If you have any questions about your Plan, you should contact the 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, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.