2016 Chevron Health Plan Changes

This section describes the changes to your benefits that take effect on January 1, 2016.

This section of the newsletter (Page 11 - 39) serves as an official summary of material modification (SMM) to the summary plan description (SPD) book(s) for the plans referenced herein. **Please keep this information with your other plan documents for future reference.** This SMM provides only certain information about changes of benefit provisions. It is not intended to be a complete explanation. If there are any discrepancies between this SMM 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.

Summary plan descriptions (SPDs) provide detailed information about your Chevron benefit plans such as eligibility, claims and participation. You can get the **Your Chevron Benefits for Retirees** SPD in two ways:

- **Online.** Visit **hr2.chevron.com/retiree** and choose the **Health and Welfare** tab.
- **By phone.** To request a printed free copy by mail, contact the HR Service Center at 1-888-825-5247 (610-669-8595 outside the U.S.) and select option 2.

All Retirees ...

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Eligible for Medicare ...

Page 32 Medicare Plus Plan, Medicare Standard Plan, Senior Care Plan

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Dental Plans

There are no plan changes to the **Dental HMO** or **Dental PPO Plans** in 2016. A Dental HMO option may be available to you in your area. The personal enrollment worksheet included in this open enrollment package will list any Dental HMOs available to you next year.

Be sure to review the enclosed personal enrollment worksheet to review your actual 2016 cost information, including the amount Chevron will contribute to your coverage. Your cost for coverage under the **Dental PPO Plan** will *increase* by approximately **2%** for 2016. Depending on the plan, the monthly premiums for some **Dental HMO** plans will *decrease* by approximately **5%**, while other Dental HMO plans will *increase* by up to **7%**.

Vision

Retirees enrolled the **Medical PPO Plan,** the **High Deductible Health Plan,** the **Medicare Plus Plan,** the **Medicare Standard Plan** and the **Senior Care Plan** are automatically enrolled in the Vision Program for basic vision coverage. There are no plan changes to the Vision Program in 2016. VSP is the insurer for your vision coverage. The VSP provider network is made up of primarily private practice vision providers across the United States. All VSP private practice doctors provide exams and have materials, such as glasses and contacts, available in their offices. The plan provides 100 percent coverage for an annual comprehensive eye exam, including dilation as needed, from a network provider. If you have questions about your vision coverage, contact VSP at **1-800-877-7195**, or go to **www.vsp.com/go/chevron**.

If you're enrolled in a **Medical HMO** or **Medicare Medical HMO Plan,** vision services (if any) are provided through your Medical HMO Plan.

Medical PPO Plan (Option 1, Option 2)

2016 Monthly Cost Overview

Be sure to review the enclosed personal **enrollment worksheet** with your actual 2016 cost information, including the amount Chevron will contribute to your coverage. Chevron's company contribution for retiree coverage to all non-Medicare medical plans for 2016 will remain the same amount as for 2015.

As you know, Chevron currently shares the monthly cost of coverage – the premium – for your medical and dental plans. Our total premium cost is determined, in part, by the actual health care expenses incurred by the plans in the previous year. As a result of higher than expected health claims experience, the monthly premiums for the **Medical PPO Plan** will *increase* by an average of **24% for Option 1** and **26% for Option 2** in 2016, depending on when you retired.

Changes to Medical Coverage

- Currently, the Medical PPO Plan requires that another method of pain management has been tried and failed before **acupuncture coverage** begins. This requirement will be removed effective January 1, 2016.

- Effective January 1, 2016, **virtual visits** are available for covered health services that include the diagnosis and treatment of low acuity medical conditions for covered persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling 1-800-654-0079.

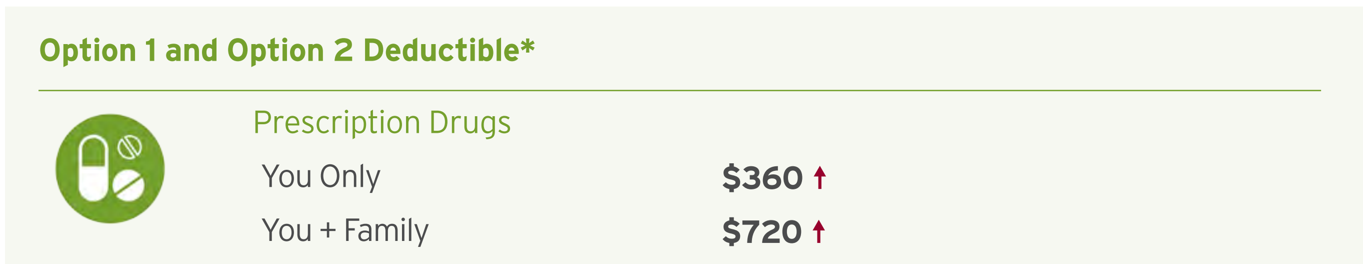
  Note that not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person physician contact is necessary. In addition, benefits under this provision do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities.

Changes to Prescription Drug Coverage

If you are enrolled in the **Medical PPO Plan**, you automatically have prescription drug coverage through the Prescription Drug Program with Express Scripts. The prescription drug changes described in this section take effect on January 1, 2016. For additional details, contact Express Scripts Member Services at **1-800-987-8368,** or review the documents and links available from **hr2.chevron.com/retiree.** Choose the **Open Enrollment** link to get started.

Deductible Increase

There is a separate deductible for prescription drugs under the **Medical PPO Plan.**



Option 1 and Option 2 Deductible*

Prescription Drugs	
You Only	**$360** ↑
You + Family	**$720** ↑

** For Option 1 and Option 2, each covered individual has a maximum deductible equal to the You Only deductible amount. No more than the You Only deductible amount can be applied toward the family deductible for any one person to satisfy the You + Family deductible.*

New Prior Authorizations

The Prescription Drug Program covers some drugs only if they're prescribed for certain uses or only up to certain quantity levels. For this reason, some medications will require your doctor to provide additional clinical information so that use of the medication can be approved in advance before you can receive plan benefits. This is called **prior authorization**. The following drugs will require prior authorization effective January 1, 2016:

- Anticoagulants (Pradaxa, Xarelto, Eliquis)
- Suboxone

New Medications Subject to Preferred Step Therapy

Certain drugs are covered by the Prescription Drug Program only if preferred drugs — which include generics — are tried first. This is called **Preferred Step Therapy (PST)**. The following are new classes of medications that will be subject to PST effective January 1, 2016. This means that you will be required, when clinically appropriate, to try a preferred drug before Express Scripts will authorize coverage for the use of non-preferred drugs:

- **Topical Acne**
  (For example: Cleocin T, Ancanya, Ziana, Veltin, Benzac AC, Azelex)
- **Topical Corticosteroids**
  (For example: Synalar, Cordran, Halog, Topicort, Diprolene)

Some Compound Medications Not Covered

According to the FDA, compounding is the practice in which a licensed pharmacist combines, mixes or alters ingredients in response to a prescription to create a medication tailored to the medical needs of an individual patient. Individual active ingredients within the compound might be FDA approved, but the FDA does not approve the quality, safety and efficacy of the actual compound with multiple active ingredients.

A number of these commonly used primary ingredients for compounds have been identified and will no longer be covered by the Chevron Prescription Drug Program. These include, but are not limited to, powder forms of various pain and anti-inflammatory agents. **Beginning January 1, 2016, if you are using a compound medication in which the primary ingredient is one of these agents, and it's in a dosage form such as a bulk powder, the medication will no longer be covered.**

For a few of the agents and powders, there are commercially available products that don't require a compounded product. Only your medical provider and you can determine a suitable alternative since it is often difficult to determine the condition for which a compounded medication is being prescribed. **If you continue to use the affected compounded medications, you will pay the full retail price if you refill that prescription starting January 1, 2016.**

Please note that not all compounded prescriptions are being excluded from coverage. There is still an inclusion list of compound ingredients that will remain covered and are considered appropriate. For example, certain pediatric compounds remain covered.

If you are currently taking or are prescribed a compound medication, you can call **Express Scripts Member Services at 1-800-987-8368** to verify if your medication is covered or excluded. After January 1, 2016, you can also go to the Express Scripts website at **www.express-scripts.com** and search for your medication to verify the coverage status.

PCSK9 Inhibitor Drug Class

New Prior Authorization Program

The FDA has approved the first formulas in a new class of cholesterol-lowering maintenance drugs called **PCSK9 inhibitors**. These new drugs are self-injectable specialty medications. Although studies are still underway, PCSK9 inhibitors may be used alone or in combination with current statin drugs to further lower the hardest-to-treat elevated cholesterol levels for patients who cannot tolerate any statin drug. This new generation of injectable biologics could offer an alternative for statin-intolerant patients.

While these new drugs will offer an alternative to statins, they may not be right for everyone. In addition, these drugs have the potential to drastically increase prescription drug costs under our **Medical PPO Plan** for both you and Chevron.

In an effort to provide appropriate access to this new class of drugs while protecting plan costs, Express Scripts started the Cholesterol Care Value Program. This is a separate prior authorization program designed specifically for the new PCSK9 inhibitor drug class. This prior authorization program features:

- **A clinical review process by a dedicated clinical team.** With every new request for PCSK9 inhibitors, a dedicated Express Scripts clinical team, with pharmacists who specialize in cardiovascular disease, will employ a robust clinical review, which includes collecting clinical documentation and holding discussions with your physician, before approving your use of a PCSK9 inhibitor.
- **Enhanced care for patients starting PCSK9s.** If you're changing therapy, you will automatically receive assistance and education from the Cholesterol Care team at Accredo, the Express Scripts specialty pharmacy. Accredo, will initially dispense three, 30-day prescriptions to ensure therapy tolerance before moving to a 90-day fill.

If you have questions, contact Express Scripts Member Services at **1-800-987-8368.**

High Deductible Health Plan (HDHP)

The **Chevron HDHP** is available to retirees and their dependents who are *not* enrolled in Medicare. The HDHP is a preferred provider organization (PPO) health plan that includes medical coverage with UnitedHealthcare, prescription drug coverage with Express Scripts, and Mental Health Substance Abuse coverage with Value Options. In addition, if you enroll in the HDHP, you're also automatically enrolled in the Vision Program for basic vision coverage with VSP. You can choose to see any provider you want; however, higher benefits are paid when go to a network provider. With this plan you pay a low monthly premium in exchange for a high deductible. Participants enrolled in the HDHP may also be eligible to open and contribute to a health savings account (HSA).

2016 Monthly Cost Overview

Be sure to review the enclosed personal **enrollment worksheet** with your actual 2016 cost information, including the amount Chevron will contribute to your coverage. Chevron's company contribution for retiree coverage to all non-Medicare medical plans for 2016 will remain the same amount as for 2015.

Chevron currently shares the monthly cost of coverage – the premium – for your medical and dental plans. Our total premium cost is determined, in part, by the actual health care expenses incurred by the plans in the previous year. As a result of higher than expected health claims experience, the monthly premiums for the **High Deductible Health Plan** will *increase* by an average of **32%** for 2016.

Health Savings Account (HSA) Reminders

If you enroll in the HDHP, you may be eligible to enroll in and contribute to a **health savings account (HSA)**, as long as you aren't enrolled in Medicare. An HSA is like a savings plan for health care. You can use an HSA to pay for qualified health care expenses this year, three years from now or at any point in the future. If you decide to change medical plans and leave the HDHP in 2016, and you have an established health savings account, you can continue to use the funds in your HSA to pay for qualified health care expenses.

Participation in an HSA is voluntary and is subject to strict enrollment requirements governed by the IRS. For example, you are not eligible to enroll in an HSA if you have coverage under another medical plan, including Medicare, *unless* it's another high deductible health plan or other permitted coverage. If you are enrolled in Medicare, you cannot open or continue to contribute to an HSA; however you can continue to use existing HSA funds to pay for qualified health care expenses. You are responsible for understanding how an HSA works and making contributions.

You can choose from HSAs offered by any financial institution that offers them, including the Chevron Federal Credit Union, but it's up to you to find the one that meets your needs. Chevron does not provide an HSA to retirees, and Chevron cannot offer counsel about HSAs. Be sure to consult with your financial advisor about your personal situation.

You can read about HSA eligibility requirements at **www.irs.gov**, *Publication 969* or learn about HSA qualified expenses in *Publication 502*.

IRS Limits Your Contributions to an HSA

The IRS limits how much you can contribute your HSA between January 1 and December 31 of each year. Your contribution limits are determined by the level of coverage (such as *You Only* or *You + One Adult)* you've selected in a qualifying, high deductible health plan such as the Chevron HDHP. Monitor your contributions carefully. It is your responsibility to track the total contributions you make during the year; Chevron cannot track your contributions against the annual limit. If you contribute over the limit, you may be subject to taxes and penalties. For 2016 the limits are:*

- **You Only:** $3,350
- **You + One Adult:** $6,750 ↑
- **You + Child(ren):** $6,750 ↑
- **You + Family:** $6,750 ↑

**You are allowed to make an extra $1,000 in catch-up contributions starting in the calendar year in which you turn age 55.*

Changes to Medical Coverage

- Currently, the HDHP requires that another method of pain management has been tried and failed before **acupuncture coverage** begins. This requirement will be removed effective January 1, 2016.
- Effective January 1, 2016, **virtual visits** are available for covered health services that include the diagnosis and treatment of low acuity medical conditions for covered persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling 1-800-654-0079.

  Note that not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person physician contact is necessary. In addition, benefits under this provision do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities.

Changes to Prescription Drug Coverage

If you are enrolled in the **High Deductible Health Plan**, you automatically have prescription drug coverage through the Prescription Drug Program with Express Scripts. The prescription drug changes described in this section take effect on January 1, 2016. For additional details, contact Express Scripts Member Services at **1-800-987-8368**, or review the documents and links available from **hr2.chevron.com/retiree**. Choose the **Open Enrollment** link to get started.

New Prior Authorizations

The Prescription Drug Program covers some drugs only if they're prescribed for certain uses or only up to certain quantity levels. For this reason, some medications will require your doctor to provide additional clinical information so that use of the medication can be approved in advance before you can receive plan benefits. This is called **prior authorization**. The following drugs will require prior authorization effective January 1, 2016:

- Anticoagulants (Pradaxa, Xarelto, Eliquis)
- Suboxone

New Medications Subject to Preferred Step Therapy

Certain drugs are covered by the Prescription Drug Program only if preferred drugs — which include generics — are tried first. This is called **Preferred Step Therapy (PST).** The following are new classes of medications that will be subject to PST effective January 1, 2016. This means that you will be required, when clinically appropriate, to try a preferred drug before Express Scripts will authorize coverage for the use of non-preferred drugs:

- **Topical Acne**
  (For example: Cleocin T, Ancanya, Ziana, Veltin, Benzac AC, Azelex)
- **Topical Corticosteroids**
  (For example: Synalar, Cordran, Halog, Topicort, Diprolene)

Some Compound Medications Not Covered

According to the FDA, compounding is the practice in which a licensed pharmacist combines, mixes or alters ingredients in response to a prescription to create a medication tailored to the medical needs of an individual patient. Individual active ingredients within the compound might be FDA approved, but the FDA does not approve the quality, safety and efficacy of the actual compound with multiple active ingredients.

A number of these commonly used primary ingredients for compounds have been identified and will no longer be covered by the Chevron Prescription Drug Program. These include, but are not limited to, powder forms of various pain and anti-inflammatory agents. **Beginning January 1, 2016, if you are using a compound medication in which the primary ingredient is one of these agents, and it's in a dosage form such as a bulk powder, the medication will no longer be covered.**

For a few of the agents and powders, there are commercially available products that don't require a compounded product. Only your medical provider and you can determine a suitable alternative since it is often difficult to determine the condition for which a compounded medication is being prescribed. **If you continue to use the affected compounded medications, you will pay the full retail price if you refill that prescription starting January 1, 2016.**

Please note that not all compounded prescriptions are being excluded from coverage. There is still an inclusion list of compound ingredients that will remain covered and are considered appropriate. For example, certain pediatric compounds remain covered.

If you are currently taking or are prescribed a compound medication, you can call **Express Scripts Member Services at 1-800-987-8368** to verify if your medication is covered or excluded. After January 1, 2016, you can also go to the Express Scripts website at **www.express-scripts.com** and search for your medication to verify the coverage status.

PCSK9 Inhibitor Drug Class

New Prior Authorization Program

The FDA has approved the first formulas in a new class of cholesterol-lowering maintenance drugs called **PCSK9 inhibitors**. These new drugs are self-injectable specialty medications. Although studies are still underway, PCSK9 inhibitors may be used alone or in combination with current statin drugs to further lower the hardest-to-treat elevated cholesterol levels for patients who cannot tolerate any statin drug. This new generation of injectable biologics could offer an alternative for statin-intolerant patients.

While these new drugs will offer an alternative to statins, they may not be right for everyone. In addition, these drugs have the potential to drastically increase prescription drug costs under our Medical PPO Plan for both you and Chevron.

In an effort to provide appropriate access to this new class of drugs while protecting plan costs, Express Scripts started the Cholesterol Care Value Program. This is a separate prior authorization program designed specifically for the new PCSK9 inhibitor drug class. This prior authorization program features:

- **A clinical review process by a dedicated clinical team.** With every new request for PCSK9 inhibitors, a dedicated Express Scripts clinical team, with pharmacists who specialize in cardiovascular disease, will employ a robust clinical review, which includes collecting clinical documentation and holding discussions with your physician, before approving your use of a PCSK9 inhibitor.
- **Enhanced care for patients starting PCSK9s.** If you're changing therapy, you will automatically receive assistance and education from the Cholesterol Care team at Accredo, the Express Scripts specialty pharmacy. Accredo, will initially dispense three, 30-day prescriptions to ensure therapy tolerance before moving to a 90-day fill.

If you have questions, contact Express Scripts Member Services at **1-800-987-8368.**

Medical HMO Plans

Not Eligible for Medicare

A Medical HMO option may be available to you in your area. The personal enrollment worksheet included in this open enrollment package will list any HMOs available to you next year.

2016 Monthly Cost Overview

Be sure to review the enclosed personal **enrollment worksheet** with your actual 2016 cost information, including the amount Chevron will contribute to your coverage, for the HMO plans that apply to you (if any). Chevron's company contribution for retiree coverage to all non-Medicare medical plans for 2016 will remain the same amount as for 2015.

HMOs are products that Chevron purchases on behalf of our employees and retirees, and premiums are set by the HMOs based on their specific claims experience. Depending on the plan, the monthly premiums for some **Medical HMO plans** will *decrease* by approximately up to **8%**, while other plans will *increase* by approximately up to **34%**.

Medical HMO Reminders

- Even if your current Medical HMO will be available in 2016, that doesn't guarantee that it is still available to you. Each year, the HMOs review the ZIP codes and counties in which they have providers. An HMO may choose to discontinue coverage to residents of certain areas.
- Your Medical HMO provider may have changed. Remember that HMOs require you to use doctors and hospitals that are part of their provider network. Contact your medical HMO directly to find out if your current providers continue to be in the network. If they aren't, you will need to change providers or choose a new plan to ensure that your medical services continue to be covered.
- Copayment and other changes in your current Medical HMO coverage may apply because of state filings, compliance with the Health Care Reform law provisions, or to make them more closely align with Chevron's standard benefit design.
- Chevron's Medical HMOs continue to include mental health coverage. These services are offered through the HMO, *not* the Chevron Mental Health and Substance Abuse Plan.

Medical HMO - Altius UT Will Not Be Offered in 2016

This plan will no longer be available to retirees or active employees effective January 1, 2016. Retirees and their eligible dependents that are currently enrolled in this plan will be automatically enrolled in another Chevron medical plan for 2016. Participants not eligible for Medicare will be automatically enrolled in the **Medical PPO Plan – Option 1** effective January 1, 2016. Medicare-eligible participants will be automatically enrolled in the **Chevron Senior Care Plan** effective January 1, 2016. No action is required, but if you want to enroll in another Chevron medical option available to you, you must make an election during open enrollment, October 19 through October 30, 2015.

Other Medical HMO Plan Changes

If you participate in a Medical HMO offered by Chevron, note that your provider or other plan features, like monthly premiums, copayments or prescription drug coverage could still change. We've provided the highlights of major changes in the table below. But you should also refer to the **2016 Evidence of Coverage** document available for each plan to learn about additional changes not listed here. Contact the HMO directly to request a copy. You can find HMO contact information on **hr2.chevron.com/retiree** or by calling the HR Service Center.

2016 Medical HMO Plan Change Highlights

Medical HMO - Health Plan HI

- Durable Medical Equipment coverage will increase from 50% to **80% covered**.
- Hawaii mandate for **autism coverage** now included.

Medical HMO - Group Health WA

- Outpatient Rehabilitation visit limit will be reduced from 60 visits per year to **45 visits per year**.
- Inpatient Rehabilitation visit limit will be reduced from 60 days per year to **30 days per year**.

Medical HMO - Kaiser HI

- Specialty Drug tier added (**$75** retail, **$150** mail-order).
- Skilled Nursing Facility care day limit will be increased from 100 days to **120 days**.

Medical HMO - Altius UT

- This plan **will no longer be available** to retirees or active employees effective January 1, 2016. See Page 25 for more details.

Mental Health and Substance Abuse Plan

When you and any of your covered dependents enroll in the **Medical PPO Plan** or the **High Deductible Health Plan**, mental health coverage is automatically provided by the Chevron Mental Health and Substance Abuse (MHSA) Plan administered by ValueOptions, as long as you aren't eligible for Medicare. If you are enrolled in the **Medicare Plus Plan, Medicare Standard Plan**, and the **Senior Care Plan**, there is no separate mental health coverage under the MHSA Plan since coverage is provided through Medicare. When you or any of your enrolled dependents become eligible for Medicare, mental health coverage under the MHSA Plan will stop for that person because Medicare provides this benefit. However MHSA coverage will continue for other participants as long as they aren't eligible for Medicare and continue to be enrolled in the Medical PPO or High Deductible Health Plans.

The MHSA plan provides confidential support for a wide range of personal issues — from everyday challenges to more serious problems. You and your covered dependents have access to support services 24 hours a day for a variety of concerns such as:

- Depression.
- Stress and anxiety.
- Parenting and family problems.
- Relationship difficulties.

ValueOptions has merged with Beacon Health Options.

ValueOptions, the current administrator of your MHSA Plan, has merged with Beacon Health Strategies to form Beacon Health Options. There will be no changes to your MHSA Plan, other than a new logo and administrator name — **ValueOptions, a Beacon Health Options company.** Your MHSA benefits generally remain the same, with the exception of the 2016 plan design changes discussed in this newsletter.

- The **provider network** remains the same.
- The **phone number** remains the same.
- The **website address** remains the same.
- **ID cards** issued to *new* participants will reflect the new name and logo.

You will begin to see the Beacon name, logo and branding over time. For this reason, it's possible you may see some overlap of ValueOptions and Beacon Health Options branding. Providers have also started to see this change, so if your provider mentions it, there is no cause for concern.

ValueOptions, a Beacon Health Options company
1-800-847-2438
www.valueoptions.com

New Office Visit Coinsurance Maximum

Mental Health and Substance Abuse Plan
Medical PPO (Option 1, Option 2) Participants Only

Mental Health Benefits

Outpatient

Office visit (individual, group, family, medication management).

Some services require pre-certification (for example, psychological testing and electroconvulsive therapy).

Network	Out-of-Network
90% after 10% coinsurance (maximum $25) per visit.	80% of allowed charges.

Substance Abuse Benefits

Outpatient

Office visit (individual, group, family, medication management).

Network	Out-of-Network
90% after 10% coinsurance (maximum $25) per visit.	80% of allowed charges.

New Notification Requirements for Inpatient Admission

Mental Health and Substance Abuse Plan
All Eligible Participants

Mental Health Benefits

Inpatient

Acute inpatient treatment, structured outpatient treatment, intensive outpatient treatment, residential treatment and partial hospitalization.

Some services require pre-certification (for example, psychological testing and electroconvulsive therapy).

All inpatient services require notification to ValueOptions within **3** business days of admission, or within **2** business days after an emergency hospital admission.

Substance Abuse Benefits

Inpatient

Acute inpatient treatment, structured outpatient treatment, intensive outpatient treatment, residential treatment and partial hospitalization.

You must notify ValueOptions within **3** business days of admission, or within **2** business days after an emergency hospital admission.

Medicare-Eligible?

A Few Important Reminders

Be sure you're enrolled in Medicare Part A and Part B.

All Medicare plans offered by Chevron require enrollment in both Medicare Part A and Part B. For Medicare-eligible retirees, Medicare is the primary payer of claims. This means your Chevron coverage will pay claims with the assumption that both Part A and Part B have paid their share of your charges, even if you aren't enrolled in or paying for Part B. So, if you aren't enrolled in Part B, you will be responsible for a much larger share of the cost for services, and in some cases, the total cost. If you aren't enrolled in Part B, you'll need to do so during the Medicare Part B general enrollment period from **January 1** through **March 31, 2016**. To enroll in Medicare, contact Social Security at **1-800-772-1213**. Your Part B coverage will become effective July 1, 2016. If you are newly eligible for Part B benefits, you should contact Social Security for information regarding how to enroll and the specific deadline that applies to you. More information about Medicare is available online at **www.medicare.gov** or 1-800-MEDICARE (1-800-633-4227).

Becoming Medicare-Eligible Due to Age or Disability

If you or your dependent will turn age 65 during 2016, you (or your dependent) will receive information and instructions from the HR Service Center about three months before the individual's 65th birthday. Be sure to read the package and take action by the deadlines. And if you don't receive this information, please contact the HR Service Center. If you or a dependent is under age 65 and become Medicare-eligible due to a disability, it's very important that you notify the HR Service Center. That's because Medicare is the primary payer of health care claims for Medicare-eligible retirees, survivors and dependents. You must be enrolled in a Chevron-sponsored plan that coordinates with Medicare or your reimbursement for services may be affected. For example, in certain situations you could be responsible for a large portion of the cost for services. So be sure to notify the HR Service Center (Page 6) right away if you become eligible for Medicare due to a disability.

A reminder about health savings accounts.

As a reminder, if you have an existing **health savings account (HSA)** because you were enrolled in the Chevron High Deductible Health Plan (HDHP) or another permitted plan, don't forget about the strict rules surrounding contributions when you're eligible for Medicare. You can continue to contribute to an HSA as long as you're enrolled in a qualifying high deductible health plan *and you aren't enrolled in Medicare.* If you're no longer eligible to contribute to your HSA, you can still continue to use the funds in your account to pay for qualified health care expenses. When you turn 65, HSA funds can be used to pay certain insurance premiums, such as Medicare Part A, Medicare Part B, a Medicare HMO, or your share of retiree medical coverage offered by a former employer (like Chevron). You are responsible for understanding how an HSA works, qualified health care expenses, and determining if you're eligible to make contributions. You can read about the eligibility requirements at **www.irs.gov,** *Publication 969* and about qualified expenses in *Publication 502.*

Medicare Plus Plan
Medicare Standard Plan
Senior Care Plan

Chevron offers three medical plan options with UnitedHealthcare (UHC) as the claims administrator for Medicare-eligible retirees: **Medicare Plus Plan, Medicare Standard Plan** and the **Senior Care Plan**. See Page 42 for a brief comparison of the key similarities and differences among these plans.

2016 Monthly Cost Overview

Be sure to review the enclosed personal **enrollment worksheet** with your actual 2016 cost information, including the amount Chevron will contribute to your coverage, for the plans that apply to you. Chevron's company contribution for retiree coverage to all Medicare medical plans for 2016 will remain the same amount as for 2015.

Chevron currently shares the monthly cost of coverage – the premium – for your medical and dental plans. Our total premium cost is determined, in part, by the actual health care expenses incurred by the plans in the previous year. As a result of favorable health claims experience, the monthly premiums for these plans will *decrease* on average between **7%** to **11%**.

Changes to Medical Coverage

Chevron will not make changes to medical coverage — including the deductible — for the **Medicare Plus Plan**, the **Medicare Standard Plan** or the **Senior Care Plan** in 2016.

Changes to Prescription Drug Coverage

If you are enrolled in the **Medicare Plus Plan**, the **Medicare Standard Plan** or the **Senior Care Plan**, you will receive your Annual Notice of Changes for Express Scripts Medicare® (PDP) in the mail. This government-required mailing gives details about the changes to the prescription drug coverage through the Medicare Part D program administered by Express Scripts. It also includes the following documents:

- The **Express Scripts Medicare (PDP) Drug Formulary.** This document provides information about the drugs covered under your Medicare prescription drug coverage, including tier assignments.
- The **Express Scripts Medicare (PDP) Evidence of Coverage.** This document provides details about your Medicare prescription drug coverage.

Be sure to review these documents carefully to understand if there are any changes to your prescription drugs that might affect your costs. Keep these documents to reference them throughout the year. Copies are also available online at **hr2.chevron.com/retiree**. Contact

Prescription Drug Copayments

Prescription drug copayments in the **Medicare Plus Plan**, the **Medicare Standard Plan** and the **Senior Care Plan** will generally remain the same in 2016. However, if the tier status of your drug has changed, your costs may change. Consult the Annual Notice of Changes for Express Scripts Medicare® (PDP) mailed to you to check applicable drugs.

Prescription Drug Deductible

There is a separate deductible for prescription drugs under the **Medicare Plus Plan**, the **Medicare Standard Plan** and the **Senior Care Plan**. The prescription drug deductible for each plan will increase effective January 1, 2016.

Medicare Plus Plan

Deductible
Prescription Drugs
$360 per person ↑

Medicare Standard Plan

Deductible
Prescription Drugs
$360 per person ↑

Senior Care Plan

Deductible
Prescription Drugs
$360 per person ↑

Prescription Drug Out-of-Pocket Maximum

There is a separate out-of-pocket maximum for prescription drugs under the **Medicare Plus Plan**, the **Medicare Standard Plan** and the **Senior Care Plan**. The prescription drug out-of-pocket maximum for each plan will increase effective January 1, 2016.

Medicare Plus Plan

Out-of-Pocket Maximum
Prescription Drugs*
$4,850 per person (including deductible) ↑

Medicare Standard Plan

Out-of-Pocket Maximum
Prescription Drugs*
$4,850 per person (including deductible) ↑

Senior Care Plan

Out-of-Pocket Maximum
Prescription Drugs*
$4,850 per person (including deductible) ↑

** Once you reach the out-of-pocket maximum, the plan pays 95 percent of the remaining costs and you pay 5 percent, with a maximum not to exceed the standard cost-sharing amount during the initial coverage stage. See the Annual Notice of Changes for Express Scripts Medicare® (PDP) mailed to you for details.*

Mental Health Coverage Reminder

Mental health services will count towards the deductible and out-of-pocket maximum for the **Medicare Plus Plan**, the **Medicare Standard Plan** and the **Senior Care Plan** outlined in the summary plan description.

Medicare Medical HMO Plans

Eligible for Medicare

A Medicare HMO option may be available to you in your area. The personal **enrollment worksheet** included in this open enrollment package will list any Medical HMOs available to you next year. Please review the information on the following pages to read about what's changing in 2016 for these plans.

Chevron's Medicare HMOs continue to include prescription drug coverage. **If you enroll in a Chevron Medicare HMO, you should not enroll in a separate Medicare prescription drug plan, because you cannot be enrolled in more than one Medicare Part D prescription drug plan.**

In addition, if you're Medicare-eligible, you can't enroll in a Chevron Medicare HMO unless you have both Medicare Part A and Part B. If you aren't enrolled in Part B, you'll need to enroll during the Medicare Part B general enrollment period from **January 1** through **March 31, 2016**. To enroll in Medicare, contact Social Security at **1-800-772-1213**. Your Part B coverage will become effective July 1, 2016. If you are newly eligible for Part B benefits, you should contact Social Security for information regarding how to enroll and the specific deadline that applies to you. More information about Medicare is available online at **www.medicare.gov** or **1-800-MEDICARE (1-800-633-4227).** Contact the Medicare HMO directly with questions about your coverage.

2016 Monthly Cost Overview

Be sure to review the enclosed personal **enrollment worksheet** with your actual 2016 cost information, including the amount Chevron will contribute to your coverage, for the HMO plans that apply to you (if any). Chevron's company contribution for retiree coverage to all Medicare medical plans for 2016 will remain the same amount as for 2015.

HMOs are products that Chevron purchases on behalf of our employees and retirees, and premiums are set by the HMOs based on their specific claims experience. Depending on the plan, the monthly premiums for some **Medicare Medical HMO** plans will *decrease* by approximately up to **15%**, while other plans will *increase* by approximately up to **26%**.

Altius Health Plan Medicare Supplement Will Not Be Offered in 2016

This plan will no longer be available to retirees or active employees effective January 1, 2016. Retirees and their eligible dependents that are currently enrolled in this plan will be automatically enrolled in another Chevron medical plan for 2016. Participants not eligible for Medicare will be automatically enrolled in the **Medical PPO Plan – Option 1** effective January 1, 2016. Medicare-eligible participants will be automatically enrolled in the **Chevron Senior Care Plan** effective January 1, 2016. No action is required, but if you want to enroll in another Chevron medical option available to you, you must make an election during open enrollment, October 19 through October 30, 2015.

Other Medicare HMO Plan Changes

If you participate in a Medicare HMO offered by Chevron, note that your provider or other plan features, like monthly premiums, copayments or prescription drug coverage could still change. We've provided the highlights of major changes in the table below. But you should refer to the **2016 Evidence of Coverage** document available for each plan to learn about additional changes not listed here. Contact the Medicare HMO directly to request a copy. You can find Medicare HMO contact information on **hr2.chevron.com/retiree** or by calling the HR Service Center.

2016 Medicare Medical HMO Plan Change Highlights

Humana Group Medicare HMO

- Pharmacy *true out-of-pocket* (trOOP) increased to **$4,850**.
- For pharmacy catastrophic coverage, once the trOOP is met, the member is responsible for the greater of **$2.95** for generic/multiple source drugs (**$7.40** for all others), or **5%** coinsurance.

Health Plan Hawaii Medicare Supplement HI

- Durable Medical Equipment coverage will increase from 50% to **80%** covered.
- Hawaii mandate for **autism coverage** now included.

Kaiser Senior Advantage HI

- Specialty Drug tier added (**$75** retail, **$150** mail-order).
- Skilled Nursing Facility care day limit will be increased from 100 days to **120 days**.

Altius Health Plan Medicare Supplement

- This plan will no longer be available to retirees or active employees effective January 1, 2016. See Page 37 for more details.

Medicare HMO Reminders

- Even if your current Medicare HMO will be available in 2016, that doesn't guarantee that it is still available to you. Each year, the HMOs review the ZIP codes and counties in which they have providers. An HMO may choose to discontinue coverage to residents of certain areas.
- Your Medicare HMO provider may have changed. Remember that HMOs require you to use doctors and hospitals that are part of their provider network. Contact your medical Medicare HMO directly to find out if your current providers continue to be in the network. If they aren't, you will need to change providers or choose a new plan to ensure that your medical services continue to be covered.
- Copayment and other changes in your current Medicare HMO coverage may apply because of state filings, compliance with the Health Care Reform law provisions, or to make them more closely align with Chevron's standard benefit design.