Chevron Medical HMO Plan
Humana USW, Local 447 (140)

Coverage Period: 01/01/2019 – 12/31/2019

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: You Only | You and One Adult | You and Child(ren) | You and Family
Plan Type: HMO

Important. Please note the following additional **Limitation and Exception** that applies to the **Common Medical Event** table in this Summary of Benefits and Coverage for your Chevron HMO Medical Plan.

For the Common Medical Event: If you have mental health, behavioral health, or substance abuse needs

For the Services You May Need:

- Mental/Behavioral health outpatient services
- Mental/Behavioral health inpatient services
- Substance use disorder outpatient services
- Substance use disorder inpatient services

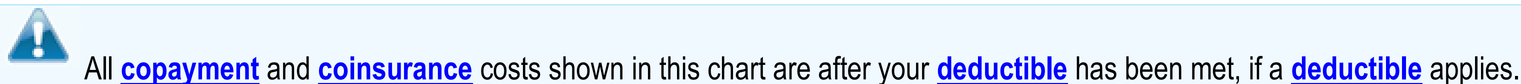
The following Limitation and Exception also applies under this plan:

Employees: You have the choice to use the benefits provided by this plan or use the benefits provided by the Chevron Mental Health and Substance Abuse (MHSA) Plan, but not both for the same service. **You must use a network provider to receive benefits, no matter which option you choose.** Out-of-network benefits are not covered by this plan, except for emergency services. Prior authorization required. For more information about the MHSA Plan benefit, call the claims administrator Beacon Health Options at 1-800-847-2438.

Retirees: Mental health and substance abuse benefits are provided exclusively through this HMO plan. You must use a network provider to receive benefits. Prior authorization required.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to hr2.chevron.com or call 1-800-448-6262. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov or call 1-866-427-7478 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No, there is no deductible to meet under this plan.	This plan covers office visits, urgent care, emergency room visits and prescription drugs even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. This plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: **$2,500** individual/**$7,500** Family. Medical and prescriptions: **$6350** Individual/**$12,700** Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan does not cover and penalties for failure to obtain pre-authorization for services	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay all costs if you use an out-of-network provider, unless treatment is for emergency services. See www.humana.com to find HMO Premier participating providers.
Do you need a referral to see a specialist?	No	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist for certain specialists.



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment;	Not covered	None
	Specialist visit	$25 copayment;	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Limitations on immunizations are according to the CDC guidelines.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Precertification is required; failure to do so can cause the service to be denied.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.humana.com and on the Well-being Center.	Generic drugs (Level 1)	Retail:$15 copayment (30-day supply); Mail order: $37.50 copayment (90-day supply)	Not covered	Plan requires use of generic drugs when available. Prior authorization and/or step therapy is required for some medicines. Maintenance medicines must be filled by Humana's Mail Order Pharmacy.
	Preferred brand drugs (Level 2)	Retail: $30 copayment (30-day supply); Mail order: $75 copayment (90-day supply)	Not covered	Plan requires use of generic drugs when available. Prior authorization and/or step therapy is required for some medicines. Maintenance medicines must be filled by Humana's Mail Order Pharmacy.
	Non-preferred brand drugs (Level 3)	Retail: $45 copayment (30-day supply); Mail order: $112.50copayment (90-day supply)	Not covered	Plan requires use of generic drugs when available. Prior authorization and/or step therapy is required for some medicines. Maintenance medicines must be filled by Humana's Mail Order Pharmacy.

*For more information about limitations and exceptions, see the plan or policy document at www.MyHumana.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	Self-administered drugs: drug copayment applies; Office administered drugs, dispensed through Humana Specialty Pharmacy: $0 copayment	Not covered	Prior authorization and/or step therapy is required for some medicines. Office administered specialty drugs not dispensed through Humana Specialty Pharmacy will be subject to applicable copayment. Specialty pharmacy and retail pharmacy Preferred pharmacy:25% copayment per specialty drug prescription/ Network pharmacy 35% copayment per .specialty drug prescription.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Precertification is required; failure to do so can cause the service to be denied.
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$100 copayment	$20 copayment	None
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$25 copayment	$5 copayment	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copayment	Not covered	Precertification is required; failure to do so can cause your service to be denied.
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment	Not covered	None
	Inpatient services	$250 copayment	Not covered	Precertification is required; failure to do so can cause the service to be denied.
If you are pregnant	Office visits	$50 copayment (one time only)	Not covered	None
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	Precertification may be required; failure to do so can cause the service to be denied.
If you need help recovering or have other special health	Home health care	No charge	Not covered	Precertification is required; failure to do so can cause the service to be denied. Limited to 60 days per year.
	Rehabilitation services	Inpatient: $250 copay	Not covered	Precertification is required; failure to do so can cause the

*For more information about limitations and exceptions, see the plan or policy document at www.MyHumana.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
needs		Outpatient: $25 copayment		service to be denied. Limited to 20 visits per year.
	Habilitation services	Inpatient: Outpatient: $250 copayment	Not covered	Precertification is required; failure to do so can cause the service to be denied. Limited to 20 visits per year.
	Skilled nursing care	$250 copayment	Not covered	Precertification is required; failure to do so can cause the service to be denied. Limited to 90 days.
	Durable medical equipment	20% coinsurance (no deductible)	Not covered	Precertification may be required. Monthly rental is allowed, but not to exceed the purchase price of DME. Includes prosthetics and orthotics.
	Hospice services	No charge	Not covered	Precertification is required; failure to do so can cause the service to be denied. Limited to 180 days.
If your child needs dental or eye care	Children's eye exam	No charge for screening	Not covered	Hardware not included.
	Children's glasses	Not covered	Not covered	No coverage for glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-ups.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids (Adults)
- Long-term care
- Non-emergency care while traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight-loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care (referral required)
- Hearing aids (for children ages 17 and younger) non-disposable aids, up to $1400 per hearing aid, every 36 months.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Humana at 1-800-448-6262 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services: See the attached Addendum.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **$5**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **0%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$110**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **$5**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,390**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$815
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,114
The total Joe would pay is	**$1,929**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **$5**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,888**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$
Copayments	$55
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$90**

The plan would be responsible for the other costs of these EXAMPLE covered services.