


Summary of Benefits and Coverage:

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

What this Plan Covers & What it Costs

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.

Questions: Call 1-888-825-5247 or visit us at hr2.chevron.com (employees) or hr2.chevron.com/retirees (retirees).

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-888-825-5247 to request a copy.

 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 www.kp.org/plandocuments or by calling 1-888-901-4636 (TTY: 711). 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.healthcare.gov/sbc-glossary or call 1-888-901-4636 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$250 Individual / \$500 Family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other Family members on the <u>plan</u> , each Family member must meet their own Individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all Family members meets the overall Family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> and services indicated in chart starting on page 2.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$2,500 Individual / \$5,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other Family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall Family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.kp.org/wa or call 1-888-901-4636 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes, but you may self-refer to certain specialists.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 / visit <u>Deductible</u> does not apply	Not covered	None
	<u>Specialist</u> visit	\$30 / visit <u>Deductible</u> does not apply	Not covered	None
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge <u>Deductible</u> does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge <u>Deductible</u> does not apply	Not covered	<u>Preauthorization</u> required or will not be covered.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.kp.org/wa .	Preferred generic drugs	Retail: \$10 / prescription; Mail Order: 2x Retail <u>cost share</u> / prescription <u>Deductible</u> does not apply	Not covered	Up to a 30-day supply (retail) or a 90 day-supply (mail order). Subject to <u>formulary</u> guidelines.
	Preferred brand drugs	Retail: \$30 / prescription; Mail Order: 2x Retail <u>cost share</u> / prescription <u>Deductible</u> does not apply	Not covered	Up to a 30-day supply (retail) or a 90 day-supply (mail order). Subject to <u>formulary</u> guidelines.
	Non-preferred generic/brand drugs	Retail: \$50 / prescription Mail Order: 2x retail <u>cost share</u> / prescription <u>Deductible</u> does not apply	Not covered	Up to a 30-day supply (retail) or a 90 day-supply (mail order). Subject to <u>formulary</u> guidelines.
	<u>Specialty drugs</u>	Applicable preferred generic, preferred brand, or non-preferred generic/brand <u>cost shares</u> may apply. <u>Deductible</u> does not apply	Not covered	Up to a 30-day supply (retail). Subject to <u>formulary</u> guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$30 / visit <u>Deductible</u> does not apply	Not covered	None
	Physician/surgeon fees	Included in Facility fee	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$100 / visit, 10% coinsurance	\$100 / visit, 10% coinsurance	You must notify Kaiser Permanente within 24 hours if admitted to a Non-network provider; Limited to initial emergency only; <u>Copayment</u> is waived if admitted as an inpatient.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> <u>Deductible</u> does not apply	20% <u>coinsurance</u> <u>Deductible</u> does not apply	None
	<u>Urgent care</u>	\$30 / visit <u>Deductible</u> does not apply	\$100 / visit, 10% coinsurance	Non-network providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	<u>Preauthorization</u> required or will not be covered.
	Physician/surgeon fees	10% coinsurance	Not covered	<u>Preauthorization</u> required or will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 / visit <u>Deductible</u> does not apply	Not covered	None
	Inpatient services	10% coinsurance	Not covered	<u>Preauthorization</u> required or will not be covered.
If you are pregnant	Office visits	10% <u>coinsurance</u>	Not covered	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	Not covered	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services: 10% <u>coinsurance</u>
	Childbirth/delivery facility services	10% coinsurance	Not covered	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services: 10% <u>coinsurance</u>
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge <u>Deductible</u> does not apply	Not covered	<u>Preauthorization</u> required or will not be covered.
	<u>Rehabilitation services</u>	Outpatient: \$30 / visit <u>Deductible</u> does not apply Inpatient: 10% coinsurance	Not covered	Outpatient: 45 visit limit / year. Inpatient: 30 day limit / year (combined with <u>Habilitation services</u>). Services with mental health diagnoses are covered with no limit. Inpatient:

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-network Provider (You will pay the most)	
				<u>Preauthorization</u> required or will not be covered.
	<u>Habilitation services</u>	Outpatient: \$30 / visit <u>Deductible</u> does not apply Inpatient: 10% coinsurance	Not covered	Outpatient: 45 visit limit / year. Inpatient: 30 day limit / year (combined with <u>Rehabilitation services</u>). Services with mental health diagnoses are covered with no limit. Inpatient: <u>Preauthorization</u> required or will not be covered.
	<u>Skilled nursing care</u>	10% coinsurance	Not covered	100 day limit / year. <u>Preauthorization</u> required or will not be covered.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> <u>Deductible</u> does not apply	Not covered	Subject to formulary guidelines. <u>Preauthorization</u> required or will not be covered.
	<u>Hospice services</u>	No charge <u>Deductible</u> does not apply	Not covered	<u>Preauthorization</u> required or will not be covered.
If your child needs dental or eye care	Children's eye exam	\$30 / visit <u>Deductible</u> does not apply	Not covered	Limited to one exam / 12 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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.)

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|-------------------------------|--|------------------------|
| • Bariatric surgery | • Hearing aids | • Private-duty nursing |
| • Children's glasses | • Long-term care | • Routine foot care |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |
| • Dental care (Adult & Child) | | |

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

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|---|-------------------------|----------------------------|
| • Acupuncture (12 visit limit / year) | • Infertility treatment | • Routine eye care (Adult) |
| • Chiropractic care (20 visit limit / year) | | |

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 shown in the chart below. 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 at: Chevron's Human Resource Center at <http://hr2.chevron.com> or by calling 1-888-825-5427 (inside the U.S.) or 610-669-8595 (outside the U.S.). For more information about your rights, this notice, or assistance, contact: The Washington Office of Insurance Commissioner at: www.insurance.wa.gov/your-insurance/health-insurance/appeal. The Insurance Consumer Hotline at 1-800-562-6900 or access to a page to email the same office: www.insurance.wa.gov/ask-us-insurance-question. Or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-888-901-4636 (TTY: 711) or www.kp.org/wa
Chevron Human Resource Center	1-888-825-5427 (inside the U.S.) or 610-669-8595 (outside the U.S.) or http://hr2.chevron.com
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov .
Washington Department of Insurance	1-800-562-6900 or www.insurance.wa.gov

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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-901-4636 (TTY: 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4636 (TTY: 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-901-4636 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-901-4636 (TTY: 711).

-----*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 \$250
- Specialist cost sharing \$30
- Hospital (facility) coinsurance 10%
- Other (blood work) coinsurance 10%

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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$30
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,540

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

- The plan's overall deductible \$250
- Specialist cost sharing \$30
- Hospital (facility) coinsurance 10%
- Other (blood work) coinsurance 10%

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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$1,000
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,410

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

- The plan's overall deductible \$250
- Specialist cost sharing \$30
- Hospital (facility) coinsurance 10%
- Other (x-ray) coinsurance 10%

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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$200
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$650

