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, visit hr2.chevron.com or contact the Chevron Human Resources Service Center at 1-888-825-5247 (1-832-854-5800 outside the U.S.). For other questions call Beacon Health Options at 1-800-847-2438 or Chevron EAP-WorkLife Services at 1-800-860-8205. 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 1-844-627-1632 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?	Yes. All mental health and substance use disorder services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	$3,000 You Only $6,000 You + One Adult $6,000 You + Child(ren) $9,000 You + 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, and health care this plan doesn't cover; your share of costs and expenses that aren't deemed medically necessary under the plan; penalties for failure to provide required notification to the plan for services; charges in excess of contracted fees for network providers; charges resulting from failure to meet this plan's notification requirements.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

Will you pay less if you use a network provider?	Yes. See www.achievesolutions.net/chevron or call 1-800-847-2438 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		U.S. Network or Non-U.S. Provider (You will pay the least)	Out-of-Network U.S. Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**U.S. Network Provider:** 10% coinsurance up to $25 maximum per visit **Non-U.S. Provider:**10% coinsurance (based on allowed charges) up to $25 maximum per visit	20% coinsurance (based on allowed charges) per visit	If you receive services in addition to an office visit, an additional copayment may apply. Services are limited to covered treatment of a mental health or substance use disorder condition.
	Specialist visit	**U.S. Network Provider:** 10% coinsurance up to $25 maximum per visit **Non-U.S. Provider:** 10% coinsurance (based on allowed charges) up to $25 maximum per visit	20% coinsurance (based on allowed charges) per visit	
	Preventive care/screening/ Immunization	Not covered	Not covered	Check with your Chevron Global Choice Plan (U.S. Payroll Expatriates) for preventive services.

* For more information about limitations and exceptions, see the plan or policy document at hr2.chevron.com or call 1-888-825-5247 for a copy.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		U.S. Network or Non-U.S. Provider (You will pay the least)	Out-of-Network U.S. Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered	Check with your Chevron Global Choice Plan (U.S. Payroll Expatriates) for other medical diagnostic care services.
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at hr2.chevron.com.	Generic drugs	Not covered	Not covered	Prescription drugs are covered only if provided specifically as part of hospital inpatient or residential treatment center care. Check with your Chevron Global Choice Plan (U.S. Payroll Expatriates) for outpatient prescription drug coverage.
	Preferred brand drugs	Not covered	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	Check with your Chevron Global Choice Plan (U.S. Payroll Expatriates) for outpatient surgery services.
	Physician/surgeon fees	Not covered	Not covered	Check with your Chevron Global Choice Plan (U.S. Payroll Expatriates) for physician/surgeon services.
If you need immediate medical attention	Emergency room care	**U.S. Network Provider:** 10% coinsurance up to $250 maximum per visit **Non-U.S. Provider:** 10% coinsurance (based on billed charges) up to $250 maximum per visit	10% coinsurance (based on billed charges) up to $250 maximum per visit	Services are limited to covered treatment of a mental health or substance use disorder condition. Check with your Chevron Global Choice Plan (U.S. Payroll Expatriates) for medical services not related to treatment of a mental health or substance use disorder condition.
	Emergency medical transportation	**U.S. Network Provider:** 10% coinsurance **Non-U.S. Provider:** 10% coinsurance (based on billed charges)	10% coinsurance (based on billed charges)	
	Urgent care	**U.S. Network Provider:** 10% coinsurance per visit **Non-U.S. Provider:** 10% coinsurance (based on billed charges) per visit	20% coinsurance (based on allowed charges) per visit	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		U.S. Network or Non-U.S. Provider (You will pay the least)	Out-of-Network U.S. Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Inpatient **mental health** services: **U.S. Network Provider:** 10% coinsurance **Non-U.S. Provider:** 10% coinsurance Inpatient **substance use disorder** services: **U.S. Network Provider:** 10% coinsurance **Non-U.S. Provider:** 10% coinsurance	20% coinsurance	For employees, no charge for the first $5,000 benefit is paid once per employee per lifetime. Services are limited to covered treatment of a mental health or substance use disorder condition. Check with your Chevron Global Choice Plan (U.S. Payroll Expatriates) for medical services not related to treatment of a mental health or substance use disorder condition.
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		U.S. Network or Non-U.S. Provider (You will pay the least)	Out-of-Network U.S. Provider (You will pay the most)	
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	**Mental health** and **substance use disorder** services: **U.S. Network Provider:** 10% coinsurance **Non-U.S. Provider:** 10% coinsurance (based on allowed charges)	20% coinsurance (based on allowed charges)	All services must meet medical necessity.
	Inpatient services	Inpatient **mental health** services: **U.S. Network Provider:** 10% coinsurance per admission **Non-U.S. Provider:** 10% coinsurance (based on allowed charges) per admission. Inpatient **substance use disorder** services: **U.S. Network Provider:** 10% coinsurance per admission after the first $5,000. . **Non-U.S. Provider:** 10% coinsurance per admission (based on allowed charges) after the first $5,000.	20% coinsurance.	All services must meet medical necessity. For employees, no charge for the first $5,000 benefit is paid once per employee per lifetime.
If you are pregnant	Office visits	Not covered	Not covered	Check with your Chevron Global Choice Plan (U.S. Payroll Expatriates) for coverage information.
	Childbirth/delivery professional services	Not covered	Not covered	
	Childbirth/delivery facility services	Not covered	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	Check with your Chevron Global Choice Plan (U.S. Payroll Expatriates) for coverage information.
	Rehabilitation services	Not covered	Not covered	
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	Not covered	Not covered	
	Durable medical equipment	Not covered	Not covered	
	Hospice services	Not covered	Not covered	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Check with your vision program for eye care coverage and your
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at hr2.chevron.com or call 1-888-825-5247 for a copy.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		U.S. Network or Non-U.S. Provider (You will pay the least)	Out-of-Network U.S. Provider (You will pay the most)	
				dental plan for dental services.

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
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult or Child)
- Durable Medical Equipment
- Hearing aids
- Home health care
- Hospice service
- Imaging (CT/PET scans, MRIs)
- Infertility treatment
- Long-term care
- Medical rehabilitation services
- Outpatient prescription drugs
- Outpatient surgery
- Pregnancy care and services
- Private-duty nursing
- Preventive care/screening/immunization
- Psychological testing unless used to diagnose a mental health disorder or when given in conjunction with a diagnosed psychiatric disorder
- Routine eye care (Adult or Child)
- Routine foot care
- Skilled nursing care
- Weight loss programs

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

Non-emergency care when traveling outside the U.S.

* For more information about limitations and exceptions, see the plan or policy document at hr2.chevron.com or call 1-888-825-5247 for a copy.

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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 on how 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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal.

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **No.**
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 1-888-825-5247.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-825-5247.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-888-825-5247.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-825-5247.

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

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* For more information about limitations and exceptions, see the plan or policy document at hr2.chevron.com or call 1-888-825-5247 for a copy.

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 coinsurance	0%
Hospital coinsurance	0%
Other coinsurance	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	**$12,700**

In this example, Peg would pay: (This condition is not covered, so patient pays 100 percent)

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,700
The total Peg would pay is	**$12,700**

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 coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	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	**$7,400**

In this example, Joe would pay: (This condition is not covered, so patient pays 100 percent)

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$7,400
The total Joe would pay is	**$7,400**

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

The plan's overall deductible	$0
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	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	**$1,900**

In this example, Mia would pay: (This condition is not covered, so patient pays 100 percent)

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,900
The total Mia would pay is	**$1,900**