


**Chevron Mental Health & Substance Use Disorder Plan:**  
**Chevron HDHP Basic Participants (110)**

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

 **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](http://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/](http://www.healthcare.gov/sbc-glossary/) or call 1-844-627-1632 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$5,000 You Only \$10,000 You + One Adult \$10,000 You + Child(ren) \$10,000 You + Family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	No.	You will have to meet the <a href="#">deductible</a> before the <a href="#">plan</a> pays for any services.
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	\$0.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$6,550 You Only \$13,100 You + One Adult \$13,100 You + Child(ren) \$13,100 You + Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover; your share of costs and expenses that aren't deemed medically necessary under the <a href="#">plan</a> ; penalties for failure to provide required notification to the plan for services; charges in excess of contracted fees for <a href="#">network providers</a> ; charges resulting from failure to	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

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 (HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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



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)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	10% <a href="#">coinsurance</a> up to \$25 maximum per visit.	20% <a href="#">coinsurance</a> (based on allowed charges) per visit.	If you receive services in addition to an office visit, an additional <a href="#">copayment</a> may apply. Services are limited to covered treatment of a mental health or substance use disorder condition.
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a> up to \$25 maximum per visit.	20% <a href="#">coinsurance</a> (based on allowed charges) per visit.	
	<a href="#">Preventive care/screening/Immunization</a>	Not covered	Not covered	Check with your Chevron HDHP Basic Plan for preventive services.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Not covered	Not covered	Check with your Chevron HDHP Basic Plan for other medical diagnostic care services.
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [hr2.chevron.com](http://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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="https://hr2.chevron.com">prescription drug coverage</a> is available at <a href="https://hr2.chevron.com">hr2.chevron.com</a> .	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 HDHP Basic Plan for outpatient prescription drug coverage.
	Preferred brand drugs	Not covered	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	
	<a href="#">Specialty drugs</a>	Not covered	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	Check with your Chevron HDHP Basic Plan for outpatient surgery services.
	Physician/surgeon fees	Not covered	Not covered	Check with your HDHP Basic Plan for physician/surgeon services.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a> up to \$250 maximum per visit	10% <a href="#">coinsurance</a> (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 HDHP Basic Plan for medical services not related to treatment of a mental health or substance use disorder condition.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a> (based on billed charges)	
	<a href="#">Urgent care</a>	10% <a href="#">coinsurance</a> per visit	20% <a href="#">coinsurance</a> (based on allowed charges) per visit	

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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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Inpatient <b>mental health</b> services: 10% <a href="#">coinsurance</a>  Inpatient <b>substance use disorder</b> services: 10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Reminder: Covered services are subject to the combined annual deductible.  Services are limited to covered treatment of a mental health or substance use disorder condition. Check with your Chevron HDHP Basic Plan for medical services not related to treatment of a mental health or substance use disorder condition.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	<b>Mental health and substance use disorder</b> services:  10% <a href="#">coinsurance</a> per visit	20% <a href="#">coinsurance</a> (based on allowed charges) per visit	All services must meet medical necessity.
	Inpatient services	Inpatient <b>mental health</b> services: 10% <a href="#">coinsurance</a> per admission  Inpatient <b>substance use disorder</b> services: 10% <a href="#">coinsurance</a> per admission after the first \$5,000.	20% <a href="#">coinsurance</a>	For employees, no charge for the first \$5,000 benefit is paid once per employee per lifetime.  All services must meet medical necessity.
If you are pregnant	Office visits	Not covered	Not covered	Check with your Chevron HDHP Basic Plan for coverage information.
	Childbirth/delivery professional services	Not covered	Not covered	
	Childbirth/delivery facility services	Not covered	Not covered	

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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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Not covered	Not covered	Check with your Chevron HDHP Basic Plan for coverage information.
	<a href="#">Rehabilitation services</a>	Not covered	Not covered	
	<a href="#">Habilitation services</a>	Not covered	Not covered	
	<a href="#">Skilled nursing care</a>	Not covered	Not covered	
	<a href="#">Durable medical equipment</a>	Not covered	Not covered	
	<a href="#">Hospice services</a>	Not covered	Not covered	
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	Check with your vision program for eye care coverage information and your dental plan for coverage of dental services.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

**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](#).)**

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Chiropractic care</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult or Child)</li> <li>• Durable Medical Equipment</li> <li>• Hearing aids</li> <li>• Home health care</li> </ul> | <ul style="list-style-type: none"> <li>• Hospice service</li> <li>• Imaging (CT/PET scans, MRIs)</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Medical rehabilitation services</li> <li>• Outpatient prescription drugs</li> <li>• Outpatient surgery</li> <li>• Pregnancy care and services</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Preventive care/screening/immunization</li> <li>• Psychological testing unless used to diagnose a mental health disorder or when given in conjunction with a diagnosed psychiatric disorder</li> <li>• Routine eye care (Adult or Child)</li> <li>• Routine foot care</li> <li>• Skilled nursing care</li> <li>• Weight loss programs</li> </ul> |
|--|---|---|

**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](http://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](http://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](http://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](http://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, kwijigo holne' 1-888-825-5247.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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](#) \$5,000
- [Specialist coinsurance](#) 0%
- Hospital (facility) [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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:** (This condition is not covered, so patient pays 100 percent)

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$12,700
<b>The total Peg would pay is</b>	<b>\$12,700</b>

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

- The [plan's](#) overall [deductible](#) \$5,000
- [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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:** (This condition is not covered, so patient pays 100 percent)

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$7,400
<b>The total Joe would pay is</b>	<b>\$7,400</b>

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

- The [plan's](#) overall [deductible](#) \$5,000
- [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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:** (This condition is not covered, so patient pays 100 percent)

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$1,900
<b>The total Mia would pay is</b>	<b>\$1,900</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services. Where a conflict exists between this SBC and the [plan](#) document, the [plan](#) document controls.