



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 Carelton Behavioral Health 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 ? | \$2,300 You Only | 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 . |

| | | |
|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Will you pay less if you use a network provider? | Yes. See www.carelonbh.com/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 |
|-------------------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | Network Provider (You will pay the least) | Out-of-Network 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 | 10% coinsurance 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 | 10% coinsurance up to \$25 maximum per visit | 20% coinsurance (based on allowed charges) per visit | |
| | Preventive care/screening/Immunization | Not covered | Not covered | |
| If you have a test | Diagnostic test (x-ray, blood work) | Not covered | Not covered | Check with your medical plan for other medical diagnostic care services. |
| | Imaging (CT/PET scans, MRIs) | Not covered | Not covered | |
| | 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 medical or |
| | Preferred brand drugs | Not covered | Not covered | |
| | Non-preferred brand drugs | 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 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at hr2.chevron.com . | Specialty drugs | Not covered | Not covered | prescription drug plan for outpatient prescription drug coverage. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Not covered | Not covered | Check with your medical plan for outpatient surgery services. |
| | Physician/surgeon fees | Not covered | Not covered | Check with your medical plan for physician/surgeon services. |
| If you need immediate medical attention | Emergency room care | 10% coinsurance 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 medical plan for medical services not related to treatment of a mental health or substance use disorder condition. |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance (based on billed charges) | |
| | Urgent care | 10% coinsurance up to \$25 maximum per visit | 20% coinsurance (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) | 10% coinsurance per admission with notification to Carelon Behavioral Health within 3 business days of admission. 40% coinsurance per admission without notification to Carelon Behavioral Health. | 20% coinsurance (based allowed charges) per admission with notification to Carelon Behavioral Health within 3 business days of admission. 40% coinsurance (based on allowed charges) per admission without notification to Carelon Behavioral Health. | Services are limited to covered treatment of a mental health or substance use disorder condition. Check with your medical plan for medical services not related to treatment of a mental health or substance use disorder condition. |
| | Physician fees | | | |

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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 need mental health, behavioral health, or substance use disorder services | Outpatient services | 10% coinsurance up to \$25 maximum per visit | 20% coinsurance (based on allowed charges) per visit | All services must meet medical necessity. |
| | Inpatient services | 10% coinsurance per admission with notification to Carelon Behavioral Health within 3 business days of admission. 40% coinsurance per admission without notification to Carelon Behavioral Health. | 20% coinsurance (based on allowed charges) per admission with notification to Carelon Behavioral Health within 3 business days of admission. 40% coinsurance (based on allowed charges) per admission without notification to Carelon Behavioral Health. | All services must meet medical necessity. |
| If you are pregnant | Office visits | Not covered | Not covered | Check with your medical plan 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 medical plan 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 | |

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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 your child needs dental or eye care | 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](#).)

- 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.

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.

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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, 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.

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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 \(facility\) 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*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

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 |
| 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)

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| 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)

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