Chevron Medical HMO Plan – Health Plan HI (130)

Coverage Period: 01/01/2020 – 12/31/2020

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

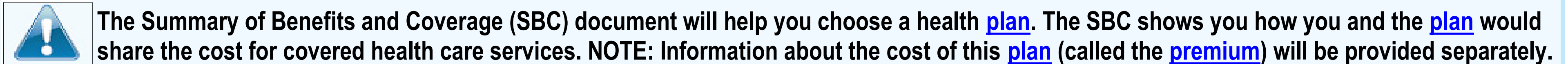
For the Services You May Need:

- 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 Use Disorder (MHSUD) 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 MHSUD Plan benefit, call the claims administrator Beacon Health Options at 1-800-847-2438.

Retirees: Mental health and substance use disorder 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, visit www.hmsa.com.

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 http://www.healthcare.gov/sbc-glossary/ or call 1-800-776-4672 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.	This plan does not have a deductible. You do not have to meet a deductible amount before the plan pays for any services.
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?	**$2,500** individual / **$7,500** family (applies to medical plan coverage). **$3,600** individual / **$4,200** family (applies to prescription drug coverage).	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-billed charges, payments for services subject to a maximum once you reach the maximum, any amounts you owe in addition to your copayment for covered services, and health care this plan doesn't cover.	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 http://www.hmsa.com/search/providers or call 1-800-776-4672 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?	Yes.	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.

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	$20 copay/visit	Not covered	---none---
	Specialist visit	$20 copay/visit	Not covered	---none---
	Other practitioner office visit:			
	Physical and Occupational Therapist	$20 copay/visit	Not covered	Services may require preauthorization. Benefits may be denied if preauthorization is not obtained.
	Psychologist	$20 copay/visit	Not covered	---none---
	Nurse Practitioner	$20 copay/visit	Not covered	---none---
	Preventive care (Well Child Physician Visit)	No charge	Not covered	Age and frequency limitations may apply. 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.
	Screening	No charge	Not covered	
	Immunization (Standard and Travel)	No charge	Not covered	
If you have a test	**Diagnostic test**			
	Inpatient	10% coinsurance	Not covered	Services may require preauthorization. Benefits may be denied if preauthorization is not obtained.
	Outpatient	20% coinsurance	Not covered	
	X-ray			
	Inpatient	10% coinsurance	Not covered	Services may require preauthorization. Benefits may be denied if preauthorization is not obtained.
	Outpatient	$10 copay/test	Not covered	
	Blood Work			
	Inpatient	10% coinsurance	Not covered	Services may require preauthorization. Benefits may be denied if preauthorization is not obtained.
	Outpatient	$10 copay/test	Not covered	
	Imaging (CT/PET scans, MRIs)			
	Inpatient	10% coinsurance	Not covered	Services may require preauthorization. Benefits may be denied if preauthorization is not obtained.
	Outpatient	20% coinsurance	Not covered	

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 www.hmsa.com.	Tier 1 – mostly Generic drugs (retail)	$7 copay/prescription	$7 copay and 20% coinsurance/prescription	One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply.
	Tier 1 – mostly Generic drugs (mail order)	$11 copay/prescription	Not covered	One mail order copay for a 84-90 day supply at a 90 day at retail network or contracted mail order provider.
	Tier 2 – mostly Preferred Formulary Drugs (retail)	$30 copay/prescription	$30 copay and 20% coinsurance/prescription	One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply.
	Tier 2 – mostly Preferred Formulary Drugs (mail order)	$65 copay/prescription	Not covered	One mail order copay for a 84-90 day supply at a 90 day at retail network or contracted mail order provider.
	Tier 3 – mostly Non-preferred Formulary Drugs (retail)	$30 copay/prescription	$30 copay and 20% coinsurance/prescription	In addition to your copay and/or coinsurance, you will be responsible for a **$45 Tier 3 Cost Share per retail copay.** Cost to you for retail Tier 3 drugs: One copay plus one Tier 3 Cost Share for 1-30 day supply, two copays plus two Tier 3 Cost Shares for 31-60 day supply, and three copays plus three Tier 3 Cost Shares for 61-90 day supply.
	Tier 3 – mostly Non-preferred Formulary Drugs (mail order)	$65 copay/prescription	Not covered	In addition to your copay and/or coinsurance, you will be responsible for a **$135 Tier 3 Cost Share per mail order copay.** Cost to you for mail order Tier 3 drugs: One mail order copay plus one mail order Tier 3 Cost Share for an 84-90 day supply at a 90 day at retail network or contracted mail order provider.

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 www.hmsa.com.	Tier 4 – mostly Preferred Formulary Specialty drugs (retail)	$100 copay/prescription	Not covered	Retail benefits for Tier 4 and Tier 5 drugs are limited to a 30-day supply. Available in participating Specialty Pharmacies only.
	Tier 5 – mostly Non-preferred Formulary Specialty drugs (retail)	$200 copay/prescription	Not covered	
	Tier 4 & 5 (mail order)	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	---none---
	Physician Visits	$20 copay/visit	Not covered	---none---
	Surgeon fees	$20 copay (cutting)	Not covered (cutting)	---none---
		$20 copay (non-cutting)	Not covered (non-cutting)	---none---
If you need immediate medical attention	**Emergency room care**			
	Physician Visit	No charge	No charge	---none---
	Emergency room	$100 copay/visit	$100 copay/visit	---none---
	Emergency medical transportation (air)	20% coinsurance	Not covered	Limited to air transport to the nearest adequate hospital within the State of Hawaii, except in certain situations when transportation to the continental US is necessary for critical care in accord with HMSA's medical policy. Certain exclusions apply.
	Emergency medical transportation (ground)	20% coinsurance	Not covered	Ground transportation to the nearest, adequate hospital to treat your illness or injury.
	Urgent care	$20 copay/visit	Not covered	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	---none---
	Physician Visits	10% coinsurance	Not covered	---none---
	Surgeon fee	10% coinsurance (cutting)	Not covered (cutting)	---none---
		10% coinsurance (non-cutting)	Not covered (non-cutting)	---none---

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 mental health, behavioral health, or substance abuse needs	**Outpatient services**			
	Physician services	$20 copay/visit	Not covered	---none---
	Hospital and facility services	No charge	Not covered	---none---
	Inpatient services			
	Physician services	10% coinsurance	Not covered	---none---
	Hospital and facility services	10% coinsurance	Not covered	---none---
If you are pregnant	Office visit (Prenatal and postnatal care)	10% coinsurance	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance or copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	Not covered	
	Childbirth/delivery facility services	10% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	---none---
	Rehabilitation services	$20 copay/visit	Not covered	Services may require preauthorization. Benefits may be denied if preauthorization is not obtained. Excludes cardiac rehabilitation.
	Habilitation services	Not covered	Not covered	Excluded service
	Skilled nursing care	10% coinsurance	Not covered	60 Days per Benefit Period. Includes extended care facilities (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities) to the extent care is for skilled nursing care, sub-acute care, or long-term acute care.
	Durable medical equipment	20% coinsurance	Not covered	Services may require preauthorization. Benefits may be denied if preauthorization is not obtained.
	Hospice services	No charge	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)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$20 copay/exam	Not covered	Limited to one routine vision exam per calendar year.
	Children's glasses (single vision lenses and frames selected within designated group)	Not covered	Not covered	Excluded service
	Children's dental check-up	Not covered	Not covered	Excluded service

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
- Cardiac rehabilitation
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Vision Appliances (Child)
- Weight loss programs

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

- Bariatric surgery (requires precertification)
- Chiropractic care (e.g., office visits, x-ray films – limited to services covered by this medical plan and within the scope of a chiropractor's license)
- Hearing aids (limited to one hearing aid per ear every 60 months)
- Infertility treatment (requires precertification and limited to one outpatient procedure per member per product)
- Private-duty nursing
- Routine eye care (Adult)

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: 1) 1-800-776-4672 for HMSA; 2) (808) 586-2790 for the State of Hawaii, Dept. of Commerce and Consumer Affairs – Insurance Division; 3) 1-866-444-3272 or http://www.dol.gov/ebsa/healthreform for the U.S. Department of Labor, Employee Benefits Security Administration; or 4) 1-877-267-2323 x61565 or http://www.cciio.cms.gov for the U.S. Department of Health and Human Services. Church plans are not covered by the Federal COBRA continuation coverage rules. 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:

- For group health coverage subject to ERISA, you must submit a written request for an appeal to: HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, Hawaii 96805-1958. If you have any questions about appeals, you can call us at (808) 948-5090 or toll free at 1-800-462-2085. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform. You may also file a grievance with the Insurance Commissioner. You must send the request to the Insurance Commissioner at: Hawaii Insurance Division, ATTN: Health Insurance Branch – External Appeals, 335 Merchant Street, Room 213, Honolulu, Hawaii 96813. Telephone: (808) 586-2804.
- For non-federal governmental group health plans and church plans that are group health plans, you must submit a written request for an appeal to: HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, Hawaii 96805-1958. If you have any questions about appeals, you can call us at (808) 948-5090 or toll free at 1-800-462-2085. You may also file a grievance with the Insurance Commissioner. You must send the request to the Insurance Commissioner at: Hawaii Insurance Division, ATTN: Health Insurance Branch – External Appeals, 335 Merchant Street, Room 213, Honolulu, Hawaii 96813. Telephone: (808) 586-2804.

Does this Coverage 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 Coverage Meet the Minimum Value Standard? Yes

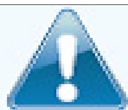
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-776-4672.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-776-4672.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-776-4672.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-776-4672.

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

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 copayment** **$20**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **20%**

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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,460**

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 copayment** **$20**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **20%**

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:	
Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,360**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **20%**

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:	
Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

Federal law requires HMSA to provide you with this notice.

HMSA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HMSA does not exclude people or treat them differently because of things like race, color, national origin, age, disability, or sex.

Services that HMSA provides

Provides aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages
- If you need these services, please call 1 (800) 776-4672 toll-free; TTY 711

How to file a discrimination-related grievance or complaint

If you believe that we've failed to provide these services or discriminated against you in some way, you can file a grievance in any of the following ways:

- Phone: 1 (800) 776-4672 toll-free
- TTY: 711
- Email: Compliance_Ethics@hmsa.com
- Fax: (808) 948-6414 on Oahu
- Mail: 818 Keeaumoku St., Honolulu, HI 96814

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, in any of the following ways:

- Online: ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Phone: 1 (800) 368-1019 toll-free; TDD users, call 1 (800) 537-7697 toll-free
- Mail: U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Building, Washington, DC 20201

For complaint forms, please go to hhs.gov/ocr/office/file/index.html.

Hawaiian: E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻŌlelo Hawaiʻi, loaʻa ke kōkua manuahi iā ʻoe. E kelepona iā 1 (800) 776-4672. TTY 711.

Bisaya: ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa 1 (800) 776-4672 nga walay toll. TTY 711.

Chinese: **注意：如果您使用繁體中文， 您可以免費獲得語言援助服務。請致電** 1 (800) 776-4672。TTY 711.

Ilocano: PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1 (800) 776-4672 toll-free. TTY 711.

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1 (800) 776-4672 をご利用ください。TTY 711. まで、お電話にてご連絡ください.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1 (800) 776-4672번으로 연락해 주시기 바랍니다. TTY 711 번으로 전화해 주십시오.

Laotian: ກະລຸນາສັງເກດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາ, ບໍ່ມີຄ່າໃຊ້ຈ່າຍ, ແມ່ນມີໃຫ້ທ່ານ. ໂທ 1 (800) 776-4672 ຟຣີ. TTY 711.

Marshallese: LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1 (800) 776-4672 tollfree, enaj ejjelok wonaan. TTY 711.

Pohnpeian: Ma ke kin lokaian Pohnpei, ke kak ale sawas in sohte pweine. Kahlda nempe wet 1 (800) 776-4672. Me sohte kak rong call TTY 711.

Samoan: MO LOU SILAFIA: Afai e te tautala Gagana **fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e** leai se totogi, mo oe, Telefoni mai: 1 (800) 776-4672 e leai se totogi o lenei ʻauʻaunaga. TTY 711.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (800) 776-4672. TTY 711.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1 (800) 776-4672 toll-free. TTY 711.

Tongan: FAKATOKANGAʻI: Kapau ʻoku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea ʻoku nau fai atu ha tokoni taʻetotongi, pea teke lava ʻo maʻu ia. Telefoni mai 1 (800) 776-4672. TTY 711.

Trukese: MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori 1 (800) 776-4672, ese kamo. TTY 711.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1 (800) 776-4672. TTY 711.

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