

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.

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, visit www.groupcertificate.humana.com or by calling 1-866-4ASSIST (427-7478). 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-866-4ASSIST (427-7478) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	Network: \$300 Individual / \$600 family; Non-Network: \$900 Individual / \$1,800 family	Generally, you must pay all of the costs from <u>providers</u> 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> ?	<u>Network Providers</u> : Yes. Certain Office Visits, Preventive, <u>Emergency Room Care</u> , <u>Urgent Care</u> , <u>Prescription Drugs</u> and Certain Therapies <u>Non-Network Providers</u> : Yes. <u>Emergency Room Care</u> and <u>Prescription Drugs</u>	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 https://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> ?	For <u>network providers</u> \$6,350 individual / \$12,700 family For non-network medical <u>providers</u> \$7,500 individual / \$15,000 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> ?	Premiums, <u>Balance-billing</u> charges, Health care this <u>plan</u> doesn't cover, Penalties, Non-network transplant, non-network <u>prescription drugs</u> , non-network <u>specialty drugs</u>	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.humana.com/directories or call 1-866-4ASSIST (427-7478) 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 <u>plan's 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 <u>provider's charge</u> 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>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</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 office</u> or clinic	Primary care visit to treat an injury or illness	Telehealth or telemedicine services: \$30 <u>copay</u> /office visit; <u>deductible</u> does not apply Primary care visit: \$30 <u>copay</u> /office visit; <u>deductible</u> does not apply	Telehealth or telemedicine services: 40% <u>coinsurance</u> Primary care visit: 40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> / immunization	No charge; <u>deductible</u> does not apply	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. 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	40% <u>coinsurance</u>	<u>Cost sharing</u> may vary based on where service is performed. Imaging: <u>Preauthorization</u> may be required - if not obtained, penalty will be 50%
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	

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)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at https://www.humana.com/2020-Rx3/</p>	Level 1 - Generic drugs	\$10 <u>copay</u> (Retail); <u>deductible</u> does not apply \$25 <u>copay</u> (Mail Order); <u>deductible</u> does not apply	30% <u>coinsurance</u> , after \$10 <u>copay</u> (Retail); <u>deductible</u> does not apply 30% <u>coinsurance</u> , after \$25 <u>copay</u> (Mail Order); <u>deductible</u> does not apply	30 day supply <u>Preauthorization</u> may be required - if not obtained, penalty will be 100% for certain <u>prescription drugs</u> (Retail) 90 day supply <u>Preauthorization</u> may be required - if not obtained, penalty will be 100% for certain <u>prescription drugs</u> (Mail Order) Non-network <u>cost sharing</u> does not count toward the <u>out-of-pocket limit</u> .
	Level 2 - Preferred brand-name drugs	\$30 <u>copay</u> (Retail); <u>deductible</u> does not apply \$75 <u>copay</u> (Mail Order); <u>deductible</u> does not apply	30% <u>coinsurance</u> , after \$30 <u>copay</u> (Retail); <u>deductible</u> does not apply 30% <u>coinsurance</u> , after \$75 <u>copay</u> (Mail Order); <u>deductible</u> does not apply	
	Level 3 - Higher-cost brand-name drugs	\$50 <u>copay</u> (Retail); <u>deductible</u> does not apply \$125 <u>copay</u> (Mail Order); <u>deductible</u> does not apply	30% <u>coinsurance</u> , after \$50 <u>copay</u> (Retail); <u>deductible</u> does not apply 30% <u>coinsurance</u> , after \$125 <u>copay</u> (Mail Order); <u>deductible</u> does not apply	
	<u>Specialty Drugs</u>	Self-administered: applicable copayment applies, depending on level of drug. <u>Office</u> administered specialty drugs, dispensed through Humana Specialty Pharmacy: \$0 copayment	50% <u>coinsurance</u> ; <u>deductible</u> does not apply	30 day supply

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required - if not obtained, penalty will be 50%
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit; <u>deductible</u> does not apply	\$100 <u>copay</u> /visit; <u>deductible</u> does not apply	<u>Emergency room care</u> : <u>Copayment</u> waived if admitted
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	
	<u>Urgent care</u>	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required - if not obtained, penalty will be 50%
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Therapy: \$30 <u>copay</u> /visit; <u>deductible</u> does not apply Other outpatient services: 10% <u>coinsurance</u>	Therapy: 40% <u>coinsurance</u> Other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Inpatient services: <u>Preauthorization</u> may be required - if not obtained, penalty will be 50%

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 are pregnant	Office visits	No charge; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Office visits: <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Childbirth/delivery professional services: Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply.
	Childbirth/delivery facility services.	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Childbirth/delivery facility services: Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <u>Preauthorization</u> may be required - if not obtained, penalty will be 50%
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	100 visit limit per year <u>Preauthorization</u> may be required - if not obtained, penalty will be 50%
	<u>Rehabilitation services</u>	Physical, occupational, speech, cognitive and audiology therapy: \$30 <u>copay</u> /visit; _____ <u>deductible</u> does not apply	Physical, occupational, speech, cognitive and audiology therapy: 40% <u>coinsurance</u>	Therapies: Physical, occupational, speech, cognitive and audiology therapy: For <u>network</u> , 20 visits per year combined For non-network, 10 visits per year combined. <u>Network</u> and non-network visit limits reduce each other.
	<u>Habilitation services</u>	Physical, occupational, speech and audiology therapy: \$30 <u>copay</u> /visit; <u>deductible</u> does not apply	Physical, occupational, speech and audiology therapy: 40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	100 day limit per year <u>Preauthorization may be required</u> - if not obtained, penalty will be 50%

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>Durable medical equipment</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required - if not obtained, penalty will be 50% Excludes vehicle and home modifications, exercise and bathroom equipment
	<u>Hospice services</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required - if not obtained, penalty will be 50%
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of other <u>excluded services</u> .)			
<ul style="list-style-type: none"> • Bariatric Surgery • Child Dental Check-Up • Child Eye Exam • Child Glasses 	<ul style="list-style-type: none"> • Infertility Treatment • Long Term Care • Non-emergency care when traveling outside of the U.S. • Private Duty Nursing 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Weight Loss Programs 	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)			
<ul style="list-style-type: none"> • Acupuncture, if it is prescribed by a physician • Chiropractic Care - spinal manipulations are covered 	<ul style="list-style-type: none"> • Cosmetic Surgery, if to correct a functional impairment • Dental Care (Adult), if for dental injury of a sound natural tooth 	<ul style="list-style-type: none"> • Hearing aids (ages 17 and younger, 80% coverage for non-disposable aids limited \$1,400 per hearing aid every 36 months) • Routine Foot Care, when in treatment for diabetes 	

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:

- www.humana.com or 1-866-4ASSIST (427-7478).
- For group health coverage subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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:

- www.humana.com or 1-866-4ASSIST (427-7478).
- Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Louisiana Department of Insurance, P.O. Box 94214, Baton Rouge, LA 70804, Phone: 800-259-5300 or 800-259-5301, Website: <http://www.lda.louisiana.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 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 1-866-4ASSIST (427-7478) (TTY: 711).

————— *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 <u>deductible</u>	\$250
■ <u>Specialist copayment</u>	\$45
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$20
Coinsurance	\$1,100
What isn't covered	
Limits or exclusions	\$10
The total Peg would pay is	\$1,330

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$250
■ <u>Specialist copayment</u>	\$45
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$1,800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,000

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$250
■ <u>Specialist copayment</u>	\$45
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$600
Coinsurance	\$50
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$850

The plan would be responsible for the other costs of these EXAMPLE covered services.

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
If you need help filing a grievance, call **1-866-427-7478** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**.

Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

Auxiliary aids and services, free of charge, are available to you. 1-866-427-7478 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. 1-866-427-7478 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi)

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

Diné Bizaad (Navajo): Wóda'í béésh bee hani'í bee wolta'ígíí bich'í' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'déé nika'adoowoł.

العربية (Arabic)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك