Insured and/or administered by:
Cigna Health and Life Insurance Company

Chevron Corporation-U.S. Payroll

Benefits at a Glance
Policy #05721A008
Plan Start January 1, 2020

This plan provides minimum essential coverage.

Please Note: This is a high level summary of your benefits. Please see your certificate booklet for detailed benefits and exclusions.

Cigna Global Customer Service		
Universal International Free Number (UIFN) **Toll Free Telephone Number:** **Direct Telephone:** **Toll Free Fax Number:** **Direct Fax Number:**	International Access Code + UIFN Toll-free number 800.441.2668.1 1.800.441.2668 1.302.797.3100 (collect calls accepted) 1.800.243.6998 001.302.797.3150	
Secure Website:	www.CignaEnvoy.com. Registration is required. (See member kit for registration information.) Secure email available at this site.	
Mail Delivery:	Cigna Global Health Benefits P.O. Box 15050 Wilmington, DE 19850-5050 U.S.A.	Cigna Global Health Benefits 300 Bellevue Parkway Wilmington, DE 19809 U.S.A

Global Medical Plan	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Eligibility	Refer to eligibility definition in the certificate		
Lifetime Maximum	Unlimited		
Calendar Year Deductible Employee	$300	$300	$300
Employee + Adult	$600	$600	$600
Employee + Child(ren)	$600	$600	$600
Family Maximum	$900	$900	$900
Coinsurance (The percentage of covered expenses the plan pays)	90%	90%	80% of the Maximum Reimbursable Charge
Out-of-Pocket Maximum Employee	$2,000	$2,000	$2,000
Employee + Adult	$4,000	$4,000	$4,000
Employee + Child(ren)	$4,000	$4,000	$4,000
Family Maximum **Excludes Deductible** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.	$6,000	$6,000	$6,000
Accumulation	Accumulation of Plan Deductible and Out-of-Pocket Maximums: Deductible and Out-of-Pocket Maximums will cross-accumulate between In-Network, Out-of-Network and International. All other plan maximums and service specific maximums (dollar and occurrence) will also cross-accumulate.		

Certification Requirements – For services rendered inside the United States

Precertification for inpatient and outpatient services received in the U.S. may be required.

- Providers must call our toll-free number, 1.800.441.2668 to pre-certify services.
- You or your dependents are responsible for ensuring that Out-of-Network providers pre-certify services.
- Failure to obtain precertification may affect Out-of-Pocket costs.
- This is a summary only and further details can be found in the certificate booklet.

Global Medical Plan

	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Physician's Services • Physician's Office Visit	100% of covered expenses after a $25 copay per visit	100% of covered expenses after a $25 copay per visit	80% of covered expenses after the deductible
• Surgery Performed In the Physician's Office	100% of covered expenses not subject to deductible	100% of covered expenses not subject to deductible	100% of covered expenses not subject to deductible
• Allergy Treatment	100% of covered expenses after a $25 copay per visit	100% of covered expenses after a $25 copay per visit	80% of covered expenses after the deductible
Preventive Care Routine Preventive Care – all ages Immunizations – all ages	100% of covered expenses not subject to deductible	100% of covered expenses not subject to deductible	100% of covered expenses not subject to deductible
Travel Immunizations (Immunizations as required for travel)	100% of covered expenses not subject to deductible	100% of covered expenses not subject to deductible	80% of covered expenses not subject to deductible
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	100% of covered expenses not subject to deductible	100% of covered expenses not subject to deductible	100% of covered expenses not subject to deductible
Inpatient Hospital Facility Services • Facility	90% of covered expenses not subject to deductible	90% of covered expenses not subject to deductible	80% of covered expenses not subject to deductible
• Physician	90% of covered expenses after the deductible	90% of covered expenses after the deductible	80% of covered expenses after the deductible
Outpatient Facility Services	90% of covered expenses after the deductible	90% of covered expenses after deductible	80% of covered expenses after deductible
Emergency Care (Refer to certificate for coverage and exclusions)	90% of covered expenses after the deductible	90% of covered expenses after the deductible	90% of covered expenses after the deductible (except if not a true emergency, then 80% of covered expenses after the deductible)

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Global Medical Plan			
	International (Outside of the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Urgent Care Services	100% of covered expenses after a $25 copay per visit	100% of covered expenses after a $25 copay per visit	100% of covered expenses after a $25 copay per visit (except if not a true emergency, then 80% of covered expenses after deductible)
Laboratory and Radiology Services (including pre-admission testing)	90% of covered expenses after the deductible	90% of covered expenses after the deductible	80% of covered expenses after deductible
Chiropractic Physician's Office Visit Visit Limits: Unlimited	100% of covered expenses	100% of covered expenses	80% of covered expenses after the deductible
Outpatient Short –Term Rehabilitative Therapy Includes Only: Physio/Physical Therapy Only Physician's Office Visit: Outpatient Hospital Facility:	100% of covered expenses 90% of covered expenses after deductible	100% of covered expenses 90% of covered expenses after deductible	80% of covered expenses after deductible 80% of covered expenses after deductible
Outpatient Short –Term Rehabilitative Therapy Includes: Cardiac Rehab Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Physician's Office Visit: Outpatient Hospital Facility: Visit Limits: Cardiac Therapy 30 Day limit All others 120 day limit Do not apply to treatment of Autism	100% of covered expenses after a $25 copay per visit 90% of covered expenses after deductible	100% of covered expenses after a $25 copay per visit 90% of covered expenses after deductible	80% of covered expenses after deductible 80% of covered expenses after deductible
Maternity Care Services • Initial Visit to Confirm Pregnancy	100% of covered expenses not subject to deductible	100% of covered expenses not subject to deductible	80% of covered expenses after the deductible
• All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	100% of covered expenses not subject to deductible	100% of covered expenses not subject to deductible	80% of covered expenses after the deductible
• Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	100% of covered expenses not subject to deductible	100% of covered expenses not subject to deductible	80% of covered expenses after the deductible
• Delivery – Facility (Inpatient Hospital, Birthing Center)	90% of covered expenses after the deductible	90% of covered expenses after the deductible	80% of covered expenses after the deductible

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Global Medical Plan			
	International (Outside of the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Infertility Procedures directly related to diagnosis and treatment are covered, including IVF. Refer to the certificate for additional coverage details.	100% of covered expenses not subject to deductible	100% of covered expenses not subject to deductible	80% of covered expenses after the deductible
Hearing Benefit • Exam: One every 12 month period	100% of covered expenses not subject to deductible	100% of covered expenses not subject to deductible	80% of covered expenses after deductible
Hearing Aid Maximum Up to $5,000 once every four Calendar Years for dependent children up to age 26	90% of covered expenses after the deductible	90% of covered expenses after the deductible	90% of covered expenses after the deductible
Mental Health and Substance Use Disorder • Inpatient Facility	Benefit provided under Chevron's mental health/substance abuse plan-please contact Value Options, a Beacon Health Options company customer service 1-800-847-2438		
• Outpatient Office Visit			

Prescription Drug Benefits	
	International (Outside of the U.S.)
Purchased outside the United States	90% of covered expenses not subject to deductible
Purchased Inside the United States Only	
U.S. RX- Benefits provided under Chevron's RX plan, please contact Express Scripts Customer Service 1-800-987-8368	

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