



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 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/ 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 ?	\$3,000 You Only \$6,000 You + One Adult \$6,000 You + Child(ren) \$9,000 You + Family	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 .

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)

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

Will you pay less if you use a network provider ?	Yes. See www.achievesolutions.net/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	Check with your Chevron Medical PPO Plan for preventive services.
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered	Check with your Chevron Medical PPO Plan for other medical diagnostic care services.
	Imaging (CT/PET scans, MRIs)	Not covered	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 hr2.chevron.com .	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 Medical PPO Plan for outpatient prescription drug coverage.
	Preferred brand drugs	Not covered	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	Check with your Chevron Medical PPO Plan for outpatient surgery services.
	Physician/surgeon fees	Not covered	Not covered	Check with your Chevron Medical PPO 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 Chevron Medical PPO 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 per visit	20% coinsurance (based on allowed charges) per visit	

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 mental health services: 10% coinsurance Inpatient substance use disorder services: 10% coinsurance .	20% coinsurance	Services are limited to covered treatment of a mental health or substance use disorder condition. Check with your Chevron Medical PPO 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	Mental health and substance use disorder services: 10% coinsurance per visit	20% coinsurance (based on allowed charges) per visit	All services must meet medical necessity.
	Inpatient services	Inpatient mental health services: 10% coinsurance Inpatient substance use disorder services: 10% coinsurance per admission after the first \$5,000.	20% coinsurance (based on allowed charges) per visit	All services must meet medical necessity.
If you are pregnant	Office visits	Not covered	Not covered	Check with your Chevron Medical PPO Plan for coverage information.
	Childbirth/delivery professional	Not covered	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)	
	services			
	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 Chevron Medical PPO 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	
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 | • Hospice service | • Private-duty nursing |
| • Bariatric surgery | • Imaging (CT/PET scans, MRIs) | • Preventive care/screening/immunization |
| • Chiropractic care | • Infertility treatment | • Psychological testing unless used to diagnose a mental health disorder or when given in conjunction with a diagnosed psychiatric disorder |
| • Cosmetic surgery | • Long-term care | • Routine eye care (Adult or Child) |
| • Dental care (Adult or Child) | • Medical rehabilitation services | • Routine foot care |
| • Durable Medical Equipment | • Outpatient prescription drugs | • Skilled nursing care |
| • Hearing aids | • Outpatient surgery | • Weight loss programs |
| • Home health care | • Pregnancy care and services | |

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. 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
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In this example, Peg would pay: (This condition is not covered, so patient pays 100 percent)

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
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
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In this example, Joe would pay: (This condition is not covered, so patient pays 100 percent)

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
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
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In this example, Mia would pay: (This condition is not covered, so patient pays 100 percent)

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

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.