aetna® **Select EPO Plan**

Coverage Period: 01/01/2017 - 12/31/2017

Coverage for: Individual + Family **Plan Type:** EPO

CHEVRON PHILLIPS CHEMICAL COMPANY LP

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.HealthReformPlanSBC.com or by calling 1-888-982-3862.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For each calendar year, in-network: Employee Only **$400**/Employee+Spouse **$800**/Employee+Child(ren) **$1,200**/Employee + Family **$1,200**. Does not apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, in-network: Employee Only **$2,000**/ Employee+Spouse **$4,000**/Employee+ Child(ren) **$6,000**/Employee + Family **$6,000**.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for services and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network **providers**, see www.aetna.com or call 1-888-982-3862.	This plan utilizes an exclusive group (in-network) of providers including doctors and other health care **providers**. This plan will only pay for the costs of covered services provided by in-network providers. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. The charges, in most cases would not be covered. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You may see any **in-network specialist** you choose without permission from this plan. There is no benefit for an out-of-network specialist except under specific conditions.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-888-982-3862 or visit us at www.HealthReformPlanSBC.com.
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.HealthReformPlanSBC.com or call 1-888-982-3862 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay per visit	Not covered	——— None ———
	Specialist visit and other practitioner office visits.	$50 copay per visit	Not covered	Chiropractic care is limited to 20 visits per calendar year.
	Preventive care /screening / immunization	No charge	Not covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance, after deductible	Not covered	——— None ———
	Imaging (CT/PET scans, MRIs)	10% coinsurance, after deductible	Not covered	——— None ———

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. **More information about prescription drug coverage is available at www.aetna.com/pharmacy-insurance/individuals-families**	Generic drugs	15% coinsurance with a $10 min/$50 max copay/prescription (retail). $25 copay/prescription (90-day supply mail-order/CVS retail).	15% coinsurance with a $10 min/$50 max copay/prescription PLUS the difference between the discounted cost and the non-discounted cost of the drug.	For maintenance medications, the plan allows the first two **30**-day fills at a retail pharmacy. After that you may obtain a **90**-day supply either through the mail-order pharmacy or at a local CVS retail pharmacy. If instead you prefer to fill your maintenance medication in a **30**-day supply quantity, you will pay a surcharge in addition to the standard coinsurance. Specific preventive drugs for specific conditions have reduced copays of $10 generic/$20 brand-name for a **30**-day supply or $20 generic/$40 brand-name for a **90**-day supply. Includes contraceptive drugs and devices obtainable from a pharmacy. No charge for formulary generic FDA-approved women's contraceptives in-network. Other programs include Generics Preferred, Prior Authorization, and Utilization Programs.
	Preferred brand drugs	20% coinsurance with a $25 min/$100 max copay/prescription (retail). $68 copay/prescription (90-day supply mail-order/CVS retail).	20% coinsurance with a $25 min/$100 max copay/prescription PLUS the difference between the discounted cost and the non-discounted cost of the drug.	
	Non-preferred brand drugs	30% coinsurance with a $45 min/$150 max copay/prescription (retail). $120 copay/prescription (90-day supply mail-order/CVS retail).	30% coinsurance with a $45 min/$150 max copay/prescription PLUS the difference between the discounted cost and the non-discounted cost of the drug.	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs.	No benefit after the initial 30-day supply.	Aetna Specialty CareRx℠ - First Prescription must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance, after deductible	Not covered	——— None ———
	Physician/surgeon fees	10% coinsurance, after deductible	Not covered	——— None ———
If you need immediate medical attention	Emergency room services	10% coinsurance, after $150 copay per visit	10% coinsurance after $150 copay per visit	No coverage for non-emergency use. Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	——— None ———
	Urgent care	$75 copay per visit	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance, after $250 copay per stay	Not covered	——— None ———
	Physician/surgeon fee	10% coinsurance, after deductible	Not covered	——— None ———
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 copay per visit	Not covered	——— None ———
	Mental/Behavioral health inpatient services	10% coinsurance, after $250 copay per stay	Not covered	——— None ———
	Substance use disorder outpatient services	$35 copay per visit	Not covered	——— None ———
	Substance use disorder inpatient services	10% coinsurance, after $250 copay per stay	Not covered	——— None ———
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	——— None ———
	Delivery and all inpatient services	10% coinsurance, after $250 copay per stay	Not covered	Includes outpatient postnatal care.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% coinsurance, after deductible	Not covered	Coverage is limited to 100 visits per calendar year.
	Rehabilitation services	Office: $50 copay per visit. Facility: 10% coinsurance, after deductible	Not covered	Coverage is limited to 60 visits per calendar year for Physical, Occupational and Speech Therapy combined.
	Habilitation services	10% coinsurance, after deductible	Not covered	Standard plan design allows for routine behavioral health services (inpatient and outpatient services, medication management, and diagnostic services). Speech therapy sessions are available up to 60 sessions per year. Applied Behavior Analysis (ABA) is excluded as it is an educational service.
	Skilled nursing care	10% coinsurance, after deductible	Not covered	Coverage is limited to 100 days per calendar year.
	Durable medical equipment	10% coinsurance, after deductible	Not covered	———— None ————
	Hospice service	10% coinsurance, after deductible	Not covered	———— None ————
If your child needs dental or eye care	Eye exam	No charge	Not covered	Age and frequency schedules may apply.
	Glasses	Not covered	Not covered	Not covered
	Dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other **excluded services**.)

- Acupuncture
- Cosmetic surgery
- Dental Care (Adult & Child)
- Glasses
- Long-term care
- Routine foot care
- Weight loss programs
- Non-emergency care when traveling outside the U.S.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care – coverage is limited to 20 visits per calendar year.
- Hearing aids
- Infertility treatment – benefit limitations may apply.
- Private-duty nursing – coverage is limited to 70 eight hour shifts per calendar year.
- Routine eye care (adult) – age and frequency schedules may apply.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-982-3862. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

- If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice or assistance, you can contact us by calling the toll free number on your Medical ID Card. 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.

- Additionally, a consumer assistance program can help you file an **appeal**. Contact information is at http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage**.

Does this Coverage Provide Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides**.

Language Access Services:

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-982-3862.

如果需要中文的帮助，请拨打这个号码 1-888-982-3862.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-982-3862.

Para obtener asistencia en Español, llame al 1-888-982-3862.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,066
- **Patient pays:** $1,474

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventative	$40
Total	**$7,540**

Patient pays:

Deductibles	$400
Copays	$250
Coinsurance	$674
Limits or exclusions	$150
Total	**$1,474**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,113
- **Patient pays:** $1,287

Sample care costs:

Prescriptions	$2,900
Medical equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventative	$100
Total	**$5,400**

Patient pays:

Deductibles	$400
Copays	$350
Coinsurance	$457
Limits or exclusions	$80
Total	**$1,287**

Note: Your plan may have both copays and **coinsurance** for covered services; if so, these examples use copays only. Your costs may be higher.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.