




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.exxonmobilfamily.com](http://www.exxonmobilfamily.com) or contact the ExxonMobil Benefit Service Center at 1-833-776-9966. 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](http://www.healthcare.gov/SBC-GLOSSARY).

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Not applicable.	You don't have to meet a <a href="#">deductible</a> before this <a href="#">plan</a> pays for any services.
Are there other <a href="#">deductibles</a> for specific services?	Not applicable.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$3,000/individual and \$6,000/family, combined medical/behavioral and <a href="#">prescription drug coverage</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and any expenses that this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	This is a network-only plan type. See <a href="http://www.aetna.com">www.aetna.com</a> or call 1-800-255-2386 for a list of medical <a href="#">network providers</a> . For behavioral health, see <a href="http://www.aetna.com">www.aetna.com</a> or call 1-800-255-2386.	This <a href="#">plan</a> uses provider <a href="#">networks</a> . You will pay full billed charges if you use a <a href="#">non-network provider</a> . However, when you get emergency care or you're treated by a <a href="#">non-network provider</a> at an in-network hospital, or ambulatory surgical center or by an air ambulance provider, you are protected from surprise billing or <a href="#">balance billing</a> .
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No. You don't need a <a href="#">referral</a> to see a <a href="#">specialist</a> .	You can see the <a href="#">specialist</a> you choose without permission from this plan.

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /visit	Not Covered	Virtual care visits covered.
	Telemedicine services	\$25 <a href="#">copay</a> /visit	Not Covered	Telemedicine is a covered benefit only when provided through Aetna's designated telemedicine provider.
	<a href="#">Specialist</a> visit	\$45 <a href="#">copay</a> /visit	Not Covered	Virtual care visits covered.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not Covered	————— <a href="#">none</a> —————
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not Covered	Prior authorization or Enhanced Clinical Review (ECR) may be required.
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	Not Covered	Prior authorization or Enhanced Clinical Review (ECR) may be required.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	\$15 <a href="#">copay</a> (short-term prescription)  \$30 <a href="#">copay</a> (long-term prescription)	Not Covered	Short-term covers prescriptions up to 34 days/fill; long-term covers ongoing prescriptions for up to 90 days/fill. Long-term prescriptions are available only at Smart90 pharmacies (CVS, Walgreens, and Express Scripts). After the third time you fill a short-term supply of a long-term medication, you must switch to a long-term prescription with a participating Smart90 pharmacy. Coverage is based on Express Scripts formulary.
	Preferred brand drugs	30% <a href="#">coinsurance</a> (short-term prescription)  25% <a href="#">coinsurance</a> (long-term prescription)	Not Covered	Max/prescription: <b>\$125</b> (short-term), <b>\$200</b> (long-term) Limitations are identical to generic drugs (see above).
	Non-preferred brand drugs	50% <a href="#">coinsurance</a>	Not Covered	Max/prescription: <b>\$200</b> (short-term), <b>\$400</b> (long-term) Limitations are identical to generic drugs (see above).
	<a href="#">Specialty drugs</a>	Same as any other prescription drug (see above).	Not Covered	Certain specialty drugs must be pre-certified and filled by Accredo, Express Scripts specialty pharmacy. Registration may be required to participate in copay assistance programs. Max/prescription and limitations are identical to any other prescription drug (see above).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	Not Covered	————— <a href="#">none</a> —————
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	Not Covered	Includes Physician/surgeon fees and all related charges.
If you need immediate	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a> /visit 10% <a href="#">coinsurance</a>	\$150 <a href="#">copay</a> /visit 10% <a href="#">coinsurance</a>	Copay waived if admitted to the hospital. Direct Access, non-emergency room services are not covered.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

<b>medical attention</b>	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	Patient is responsible for any non-covered supplies/services during transport.
	<a href="#">Urgent care</a>	\$60 <a href="#">copay</a> /visit	Not Covered	No coverage for non-urgent procedures submitted by urgent care provider.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	Not Covered	Includes Physician/surgeon fees and all related charges.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	Not Covered	
<b>If you need mental health, behavioral health, or substance abuse services (Aetna Behavioral Health)</b>	Office visits	\$25 <a href="#">copay</a> /visit	Not Covered	Virtual care visits covered.
	Outpatient services	10% <a href="#">coinsurance</a>	Not Covered	Includes applied behavior analysis for autism. Pre-authorization required on a recurring basis for continued services. No coverage for custodial care, educational services, or services performed in an academic, vocational or recreational setting.
	Inpatient services	10% <a href="#">coinsurance</a>	Not Covered	—————none—————
<b>If you are pregnant</b>	Office visits	\$25 or \$45 <a href="#">copay</a> /visit	Not Covered	—————none—————
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	Not Covered	Applies for standard Global Maternity services after initial visit to confirm pregnancy.
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	Not Covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	Not Covered	Pre-authorization required on a recurring basis for continued services. No coverage for custodial care, educational services, or services performed in an academic, vocational or recreational setting.
	<a href="#">Rehabilitation services</a>	\$45 <a href="#">copay</a> /visit	Not Covered	Includes medically necessary occupational therapy, speech therapy, and physical therapy for developmental delay.
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	Not Covered	—————none—————
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	Not Covered	—————none—————
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	Not Covered	Refer to <a href="#">National Precertification List</a> for precertification requirements, if any.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	Not Covered	Pre-certification is required.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	Limited benefits available when needed because of injury or disease.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## 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](#).)

- Bariatric surgery
- Cosmetic surgery (Unless this is medically necessary)
- Routine dental care
- Long-term care
- Non-emergency care when travelling outside the U.S.
- Non-medical ancillary services
- Routine foot care
- Routine eye care

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

- Acupuncture (if performed by a physician)
- Chiropractic care
- Fertility treatment only when provided through Progyny (833-851-2229)
- Weight loss programs (Only through Omada programs)
- Hearing Aids

**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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://www.cciio.cms.gov). 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](http://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 1-800-255-2386. You may also contact the Department of Labor's, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://www.cciio.cms.gov)

## Nondiscrimination Notice:

The ExxonMobil Medical Plan and its administrators comply with applicable federal civil rights laws and do not discriminate on the basis of race, national origin, age, disability or sex. To see the full notice of nondiscrimination for each administrator go to: [www.exxonmobilfamily.com](http://www.exxonmobilfamily.com)

## 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? 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](#).

**Disclaimer:** The health plan and benefits summarized herein are governed under law by formal Plan documents. If there is any discrepancy between the information provided in this Summary of Benefits and Coverage (SBC) and the formal Plan documents, the Plan documents control.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a>	\$45
■ Hospital (facility)	10%
■ Other	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*)

<b>Total Example Cost</b>	<b>\$11,600</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,014
<i>What isn't covered</i>	
Limits or exclusions	\$61
<b>The total Peg would pay is</b>	<b>\$1,075</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a>	\$45
■ Hospital (facility)	10%
■ Other	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$695
<a href="#">Coinsurance</a>	\$197
<i>What isn't covered</i>	
Limits or exclusions	\$22
<b>The total Joe would pay is</b>	<b>\$914</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a>	\$45
■ Hospital (facility)	10%
■ Other	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$470
<a href="#">Coinsurance</a>	\$162
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$632</b>