**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 or contact HR.Health.Welfare@exxonmobil.com. 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.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$500**/individual and **$1,000**/family for in-network and out-of-network area. **$700**/individual and **$1,400**/family for non-network. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care, in-network services that have a copayment, and prescription drug coverage are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See the SPD for details. |
| **Are there other deductibles for specific services?** | Yes. **$300** for in-network and out-of-network area inpatient hospital services, including mental health and substance abuse, and **$600** for non-network. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | For in-network and out-of-network area: **$4,500**/individual and **$9,000**/family. For non-network: **$18,000**/individual and **$36,000**/family. For prescription drug coverage, **$2,500**/individual and **$5,000**/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 any expenses that this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See **www.aetna.com** or call 1-800-255-2386 for a list of medical network providers. For behavioral health, see **www.magellanascend.com** or call 1-800-442-4123. | This plan uses provider networks. You will pay less if you use a provider in the plan's network. You will pay the most if you use a non-network provider, and you might receive a bill for the difference between the provider's charge and what your plan pays (balance billing). |
| **Do you need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the specialist 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 provider's office or clinic** | Primary care visit to treat an injury or illness | $40 copay/visit | 45% coinsurance | Not subject to annual deductible for in-network. Virtual care visits covered. The Plan pays based on a percentage of Medicare for non-network and out-of-network area providers. |
| | Telemedicine services | $40 copay/visit | 45% coinsurance | Telemedicine is a covered benefit only when provided through Aetna's designated telemedicine provider. |
| | Specialist visit | $60 copay/visit | 45% coinsurance | Not subject to annual deductible for in-network. Virtual care visits covered. The Plan pays based on a percentage of Medicare for non-network and out-of-network area providers. |
| | Preventive care/screening/ immunization | No charge | No charge | ——————none—————— |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | 45% coinsurance | The Plan pays based on a percentage of Medicare for non-network and out-of-network area providers. Prior authorization or Enhanced Clinical Review (ECR) might be required. |
| | Imaging (CT/PET scans, MRIs) | 25% coinsurance | 45% coinsurance | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at **www.express-scripts.com** | Generic drugs | 30% coinsurance (short-term prescription) 25% coinsurance (long-term prescription) | If using a non-network pharmacy, you pay 100% of the difference between the actual cost and the discounted network cost plus the short-term coinsurance. Claims must be submitted for non-network pharmacies. | Max/prescription: **$60** (short-term), **$120** (long-term). 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, or you will pay 100% of the cost. Coverage is based on Express Scripts formulary. |
| | Preferred brand drugs | 30% coinsurance (short-term prescription) 25% coinsurance (long-term prescription) | | Max/prescription: **$130** (short-term), **$260** (long-term). Limitations are identical to generic drugs (see above). |
| | Non-preferred brand drugs | 50% coinsurance (short-term prescription) 45% coinsurance (long-term prescription) | | Max/prescription: **$200** (short-term), **$400** (long-term). Limitations are identical to generic drugs (see above). |
| | Specialty drugs | Same as any other prescription drug (see above). | | 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 fill limitations are identical to any other prescription drug (see above). |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 25% coinsurance | 45% coinsurance | The Plan pays based on a percentage of Medicare for non-network and out-of-network area providers. Includes Physician/surgeon fees and all related charges. |
| | Physician/surgeon fees | 25% coinsurance | 45% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | $100 copay/visit<br>25% coinsurance | $100 copay/visit<br>25% coinsurance | Copay waived if admitted. Inpatient copayments apply upon admission. |
| | Emergency medical transportation | 25% coinsurance | 25% coinsurance | Patient is responsible for any non-covered supplies/services during transport. |
| | Urgent care | $60 copay | 45% coinsurance | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 25% coinsurance | 45% coinsurance | **$300** inpatient deductible for in-network and out-of-network area.<br>**$600** inpatient deductible for non-network.<br>**$500 penalty** if you fail to pre-certify inpatient care for non-network and out-of-network area providers.<br>The Plan pays based on a percentage of Medicare for non-network and out-of-network area providers. |
| | Physician/surgeon fees | 25% coinsurance | 45% coinsurance | The Plan pays based on a percentage of Medicare for non-network and out-of-network area providers. Includes Physician/surgeon fees and all related charges. |
| **If you need mental health, behavioral health, or substance abuse services (Magellan network and care management)** | Office visits | $40 copay/visit | 45% coinsurance | Not subject to annual deductible for in-network.<br>Virtual care visits covered.<br>The Plan pays based on a percentage of Medicare for non-network and out-of-network area providers. |
| | Outpatient services | 25% coinsurance | 45% coinsurance | 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.<br>The Plan pays based on a percentage of Medicare for non-network and out-of-network area providers. |
| | Inpatient services | 25% coinsurance | 45% coinsurance | **$300** inpatient deductible for in-network and out-of-network area.<br>**$600** inpatient deductible for non-network.<br>**$500 penalty** if you fail to pre-certify inpatient care for non-network and out-of-network area providers.<br>The Plan pays based on a percentage of Medicare for non-network and out-of-network area providers. |
| **If you are pregnant** | Office visits | $40 or $60 copay/visit | 45% coinsurance | The Plan will pay up to a maximum amount based on a percentage of Medicare. |
| | Childbirth/delivery professional services | 25% coinsurance | 45% coinsurance | **$300** inpatient deductible for in-network and out-of-network area. |

| | | | | |
|---|---|---|---|---|
| | Childbirth/delivery facility services | 25% coinsurance | 45% coinsurance | **$600** inpatient deductible for non-network.<br>**$500 penalty** if you fail to pre-certify inpatient care for non-network and out-of-network area providers.<br>The Plan pays based on a percentage of Medicare for non-network and out-of-network area providers. |
| **If you need help recovering or have other special health needs** | Home health care | 25% coinsurance | 45% coinsurance | 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.<br>The Plan pays based on a percentage of Medicare for non-network and out-of-network area providers. |
| | Rehabilitation services | 25% coinsurance | 45% coinsurance | Includes medically necessary occupational therapy, speech therapy, and physical therapy for developmental delay.<br>The Plan pays based on a percentage of Medicare for non-network and out-of-network area providers. |
| | Habilitation services | 100% after a $60 copay for each date of service | 55% after $700 deductible | ——————none—————— |
| | Skilled nursing care | 25% coinsurance | 45% coinsurance | Pre-certification required.<br>The Plan pays based on a percentage of Medicare for non-network and out-of-network area providers. |
| | Durable medical equipment | 25% coinsurance | 45% coinsurance | Refer to National Precertification List for precertification requirements, if any. |
| | Hospice services | 25% coinsurance | 45% coinsurance | **$500 penalty** if you fail to pre-certify inpatient care for non-network and out-of-network area providers.<br>The Plan pays based on a percentage of Medicare for non-network and out-of-network area providers. |
| **If your child needs dental or eye care** | 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 | |

**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.)**

- Cosmetic surgery (Unless this is medically necessary)
- Routine dental care
- Long-Term Care
- Non-medical ancillary services
- Routine eye care
- Routine foot 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)
- Bariatric surgery
- Weight loss programs (Only through Livongo StepIn program)
- Fertility treatment only when provided through Progyny (833-851-2229)
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Hearing aids

* For more information about limitations and exceptions, see the plan or policy document www.exxonmobilfamily.com

**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 , or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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, or the U.S. Department of Health and Human Services at 1-877-267- 2323 x61565 or 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

**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.

**Language Access Services:**
Spanish (Español): Para obtener asistencia en Español, comuníquese a través de HR.Health.Welfare@exxonmobil.com.

**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 plan's overall deductible | $500 |
| Specialist | $60 |
| Hospital (facility) | 25% |
| Other | 25% |

**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** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $800 |
| Copayments | $0 |
| Coinsurance | $2,925 |
| *What isn't covered* | |
| Limits or exclusions | $150 |
| **The total Peg would pay is** | **$3,875** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist | $60 |
| Hospital (facility) | 25% |
| Other | 25% |

**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** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $500 |
| Copayments | $765 |
| Coinsurance | $143 |
| *What isn't covered* | |
| Limits or exclusions | $22 |
| **The total Joe would pay is** | **$1,430** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist | $60 |
| Hospital (facility) | 25% |
| Other | 25% |

**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** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $500 |
| Copayments | $280 |
| Coinsurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,180** |

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