ExxonMobil Employee Assistance Program

Coverage for All Coverage Levels | **Plan Type:** EAP

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 the ExxonMobil Benefit Service Center at 1-800-682-2847. 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?	$0	The EAP is a preventive care program for which no deductible is applicable.
Are there services covered before you meet your deductible?	No.	The EAP is a preventive care program. You don't have to meet deductibles for EAP services.
Are there other deductibles for specific services?	No.	The EAP is a preventive care program. You don't have to meet deductibles for EAP services.
What is the out-of-pocket limit for this plan?	This plan has no out-of-pocket limit	There are no charges for EAP services obtained from a network EAP provider. As a result, there is no need for a limit on your expenses for these services.
What is not included in the out-of-pocket limit?	This plan has no out-of-pocket limit.	There are no charges for EAP services obtained from a network EAP provider. As a result, there is no need for a limit on your expenses for these services.
Will you pay less if you use a network provider?	Yes. For a list of EAP counselors, see www.guidanceresources.com (Web ID Name: **ExxonMobil**) or call 888-226-1420	If you use a network EAP provider, this plan will pay all of the costs of covered services. See the chart on page 2 for how this plan pays different kinds of providers.
Do you need a referral to see a specialist?	No.	The EAP does not cover specialists. If the EAP provider determines that you need treatment from a specialist, the EAP provider will refer you to your group health plan or treatment resources in your community.

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	Not covered	Not covered	none
	Telemedicine visit	Not covered	Not covered	none
	Specialist visit	Not covered	Not covered	none
	Preventive care/screening/ immunization	Not covered	Not covered	none
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered	none
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	none
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	Not covered	Not covered	none
	Preferred brand drugs	Not covered	Not covered	none
	Non-preferred brand drugs	Not covered	Not covered	none
	Specialty drugs	Not covered	Not covered	none
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	none
	Physician/surgeon fees	Not covered	Not covered	none
If you need immediate medical attention	Emergency room care	Not covered	Not covered	none
	Emergency medical transportation	Not covered	Not covered	none
	Urgent care	Not covered	Not covered	none
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	none
	Physician/surgeon fees	Not covered	Not covered	
If you need mental health, behavioral health, or substance abuse services	Office visits	Not covered	Not covered	none
	Outpatient services	Not covered	Not covered	none
	Inpatient services	Not covered	Not covered	none
If you are pregnant	Office visits	Not covered	Not covered	none
	Childbirth/delivery professional services	Not covered	Not covered	
	Childbirth/delivery facility services	Not covered	Not covered	none

If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	——————none——————
	Rehabilitation services	Not covered	Not covered	——————none——————
	Habilitation services	Not covered	Not covered	——————none——————
	Skilled nursing care	Not covered	Not covered	——————none——————
	Durable medical equipment	Not covered	Not covered	——————none——————
	Hospice services	Not covered	Not covered	——————none——————
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	——————none——————
	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
- Dental Care (Adult and Child)
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Long-Term Care
- Private Duty nursing (if custodial)
- Routine foot care
- Bariatric surgery
- Routine eye care (Adult and Child)
- Acupuncture
- Weight loss programs
- Infertility treatment

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

- None

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.

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	**n/a**
Specialist	**n/a**
Hospital (facility)	**n/a**
Other	**n/a**

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: This condition is not covered, so the patient pays 100%

Cost Sharing	
Deductibles	n/a
Copayments	n/a
Coinsurance	n/a
What isn't covered	
Limits or exclusions	$0
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	**n/a**
Specialist	**n/a**
Hospital (facility)	**n/a**
Other	**n/a**

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: This condition is not covered, so the patient pays 100%

Cost Sharing	
Deductibles	n/a
Copayments	n/a
Coinsurance	n/a
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$5,600**

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

The plan's overall deductible	**n/a**
Specialist	**n/a**
Hospital (facility)	**n/a**
Other	**n/a**

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: This condition is not covered, so the patient pays 100%

Cost Sharing	
Deductibles	n/a
Copayments	n/a
Coinsurance	n/a
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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