



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 1-800-682-2847. 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](http://www.healthcare.gov/SBC-GLOSSARY).

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$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 <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> , in-network services that have a <a href="#">copayment</a> , and <a href="#">prescription drug coverage</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See the SPD for details.
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	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 <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	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 <a href="#">prescription drug coverage</a> , \$2,500/individual and \$5,000/family.	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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<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> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. 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 less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use a <a href="#">non-network provider</a> , and you might receive a bill for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ).
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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 office or clinic</a>	Primary care visit to treat an injury or illness	\$40 <a href="#">copay</a> /visit	45% <a href="#">coinsurance</a>	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 <a href="#">copay</a> /visit	45% <a href="#">coinsurance</a>	Telemedicine is a covered benefit only when provided through Aetna's designated telemedicine provider.
	<a href="#">Specialist</a> visit	\$60 <a href="#">copay</a> /visit	45% <a href="#">coinsurance</a>	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.
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	—————none—————
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	45% <a href="#">coinsurance</a>	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% <a href="#">coinsurance</a>	45% <a href="#">coinsurance</a>	
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	30% <a href="#">coinsurance</a> (short-term prescription) 25% <a href="#">coinsurance</a> (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.	Max/prescription: <b>\$60</b> (short-term), <b>\$120</b> (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% <a href="#">coinsurance</a> (short-term prescription) 25% <a href="#">coinsurance</a> (long-term prescription)		
	Non-preferred brand drugs	50% <a href="#">coinsurance</a>	Claims must be submitted for non-network pharmacies.	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).		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

\* For more information about limitations and exceptions, see the [plan](#) or policy document [www.exxonmobilfamily.com](http://www.exxonmobilfamily.com)

				other prescription drug (see above).
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	25% <a href="#">coinsurance</a> <sup>1</sup>	45% <a href="#">coinsurance</a>	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% <a href="#">coinsurance</a>	45% <a href="#">coinsurance</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a> /visit 25% <a href="#">coinsurance</a>	\$100 <a href="#">copay</a> /visit 25% <a href="#">coinsurance</a>	Copay waived if admitted. Inpatient copayments apply upon admission.
	<a href="#">Emergency medical transportation</a>	25% <a href="#">coinsurance</a>	25% <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>	45% <a href="#">coinsurance</a>	_____none_____
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	25% <a href="#">coinsurance</a>	45% <a href="#">coinsurance</a>	<b>\$300</b> inpatient deductible for in-network and out-of-network area. <b>\$600</b> inpatient deductible for non-network. <b>\$500 penalty</b> if you fail to pre-certify inpatient care for non-network and out-of-network area providers. The Plan pays based on a percentage of Medicare for non-network and out-of-network area providers.
	Physician/surgeon fees	25% <a href="#">coinsurance</a>	45% <a href="#">coinsurance</a>	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.
<b>If you need mental health, behavioral health, or substance abuse services (Aetna Behavioral Health)</b>	Office visits	\$40 <a href="#">copay</a> /visit	45% <a href="#">coinsurance</a>	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.
	Outpatient services	25% <a href="#">coinsurance</a>	45% <a href="#">coinsurance</a>	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. The Plan pays based on a percentage of Medicare for non-network and out-of-network area providers.
	Inpatient services	25% <a href="#">coinsurance</a>	45% <a href="#">coinsurance</a>	<b>\$300</b> inpatient deductible for in-network and out-of-network area. <b>\$600</b> inpatient deductible for non-network. <b>\$500 penalty</b> if you fail to pre-certify inpatient care for non-network and out-of-network area providers. The Plan pays based on a percentage of Medicare for non-network and out-of-network area providers.
<b>If you are pregnant</b>	Office visits	\$40 or \$60 <a href="#">copay</a> /visit	45% <a href="#">coinsurance</a>	The Plan will pay up to a maximum amount based on a percentage of Medicare.
	Childbirth/delivery professional	25% <a href="#">coinsurance</a>	45% <a href="#">coinsurance</a>	<b>\$300</b> inpatient deductible for in-network and out-of-

<sup>1</sup> Coinsurance is applied once deductible is met.

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

**Excluded Services & Other Covered Services:**

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a>.)</b>		
<ul style="list-style-type: none"> <li>• Cosmetic surgery (Unless this is medically necessary)</li> <li>• Routine dental care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Long-Term Care</li> <li>• Non-medical ancillary services</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care</li> <li>• Routine foot care</li> </ul>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture</li> </ul>	<ul style="list-style-type: none"> <li>• Fertility treatment only when provided through Progyny</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> </ul>

\* For more information about limitations and exceptions, see the [plan](#) or policy document [www.exxonmobilfamily.com](http://www.exxonmobilfamily.com)

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

- Bariatric surgery (833-851-2229)
- Weight loss programs (Only through Omada programs)
- Chiropractic care

**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.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,696
<i>What isn't covered</i>	
Limits or exclusions	\$61
<b>The total Peg would pay is</b>	<b>\$3,557</b>

### 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*)

<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>	\$500
<a href="#">Copayments</a>	\$440
<a href="#">Coinsurance</a>	\$834
<i>What isn't covered</i>	
Limits or exclusions	\$22
<b>The total Joe would pay is</b>	<b>\$1,796</b>

### 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*)

<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>	\$500
<a href="#">Copayments</a>	\$520
<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,420</b>

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