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 call 1-800-262-2363. 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-GLOSSARYor call 1-800-262-2363 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart in page 2, for your costs for services this plan option covers.
Are there services covered before you meet your deductible?	Not applicable.	You don't have to meet a deductible before this plan pays for any services.
Are there other deductibles for specific services?	Not applicable.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$3,000**/individual and **$6,000**/family, combined medical/behavioral and prescription drug coverage.	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 health care 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?	This is a network-only plan type. See **www.Cigna.com** or call 1-800-818-9440 for a list of network providers	This plan uses a provider network. You will pay less if you use a provider in the plan's network. Unless you have a medical emergency, you will pay the full billed charges if you use a non-network provider. Be aware, your network provider might use an out-of-network provider for some services. Check with your provider or Aetna before you get services.
Do you need a referral to see a specialist?	No.	While your plan does not require a referral from your Primary Care Physician (PCP) for you to see a specialist, you will want to coordinate such care with your PCP.

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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Not Covered	Virtual care visits covered.
	Telemedicine services	$25 copay/visit	Not Covered	Telemedicine is a covered benefit only when provided through Cigna's designated telemedicine providers.
	Specialist visit	$40 copay/visit	Not Covered	Virtual care visits covered. You are encouraged to coordinate care with your PCP.
	Preventive care/screening/ immunization	No charge	Not Covered	none
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not Covered	none
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not Covered	Prior authorization may be required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com or www.cigna.com	Generic drugs	20% coinsurance	Not Covered	Max/prescription: **$105** (short-term), **$155** (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 Cigna network pharmacies. After the second time you fill a short-term supply of a long-term medication, you must switch to a long-term prescription. Coverage is based on Cigna formulary.
	Preferred brand drugs	30% coinsurance	Not Covered	Max/prescription: **$125** (short-term), **$175** (long-term) Limitations are identical to generic drugs (see above).
	Non-preferred brand drugs	45% coinsurance	Not Covered	Max/prescription: **$135** (short-term), **$200** (long-term) Limitations are identical to generic drugs (see above).
	Specialty drugs	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% coinsurance	Not Covered	Medical necessity review required for some services.
	Physician/surgeon fees	10% coinsurance	Not Covered	
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Copay is waived if admitted to the hospital.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Patient is responsible for any non-covered supplies/services during transport.
	Urgent care	$60 copay/visit	Not Covered	none

If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not Covered	Medical necessity review required for some services.
	Physician/surgeon fees	10% coinsurance	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Office visits	$40 copay/visit	Not Covered	Virtual care visits covered.
	Outpatient services	10% coinsurance	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% coinsurance	Not Covered	——none——
If you are pregnant	Office visits	$25 or $40 copay/visit	Not Covered	——none——
	Childbirth/delivery professional services	10% coinsurance	Not Covered	Applies for standard Global Maternity services after initial visit to confirm pregnancy.
	Childbirth/delivery facility services	10% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	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.
	Rehabilitation services	$40 copay/visit	Not Covered	Coverage is limited to 60 days combined annual maximum. Limitation is waived for medically necessary occupational therapy, speech therapy, and physical therapy for mental health conditions.
	Habilitation services	Not Covered	Not Covered	——none——
	Skilled nursing care	10% coinsurance	Not Covered	Pre-authorization required. Coverage is limited to 60 days annual maximum stay in a skilled nursing facility.
	Durable medical equipment	10% coinsurance	Not Covered	Pre-authorization required.
	Hospice services	10% coinsurance	Not Covered	Pre-authorization required.
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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Routine dental and eye care
- Hearing aids
- Long-Term Care
- Non-emergency care outside the U.S.
- Non-medical ancillary services
- Routine foot care

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Fertility treatment only when provided through Progyny (833-851-2229)	• Weight loss programs

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, llame al 1-800-262-2363

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.

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

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	**$0**
Specialist	**$40**
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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$1,250
What isn't covered	
Limits or exclusions	$150
The total Peg would pay is	**$1,400**

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

The plan's overall deductible	**$0**
Specialist	**$40**
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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$605
Coinsurance	$153
What isn't covered	
Limits or exclusions	$22
The total Joe would pay is	**$780**

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

The plan's overall deductible	**$0**
Specialist	**$40**
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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$270
Coinsurance	$210
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$480**

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