ExxonMobil Employee Health Advisory Program

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 01/01/2020 – 12/31/2020

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

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://www.exxonmobilfamily.com/en/health/ehap or by calling **1-800-262-2363**.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	The EHAP is a preventive care program for which no deductible is applicable.
Are there services covered before you meet your deductible?	No.	The EHAP is a preventive care program. You don't have to meet deductibles for EHAP services.
Are there other deductibles for specific services?	No.	The EHAP is a preventive care program. You don't have to meet deductibles for EHAP services.
What is the out-of-pocket limit for this plan?	This plan has no out-of-pocket limit	There are no charges for EHAP services obtained from a network EHAP 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.	Not applicable because there's no out-of-pocket limit on your expenses
Will you pay less if you use a network provider?	Yes. For a list of EHAP counselors, see www.magellanhealth.com member or call 1-800-442-4123.	If you use a network EHAP 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 EHAP does not cover specialists. If the EHAP provider determines that you need treatment from a specialist, the EHAP 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)	Non-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——————
	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.[insert].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	——————none——————

* For more information about limitations and exceptions, see the plan or policy document at http://www.exxonmobilfamily.com/en/health/ehap

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	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	————————none————————
	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	————————none————————
	Children's dental check-up	Not covered	Not covered	————————none————————

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)
- Acupuncture (if performed by a physician)
- Bariatric surgery
- Infertility treatment
- Long-Term Care
- Private –Duty nursing (if custodial)
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult and Child)
- Routine foot care
- Weight loss programs (only morbid obesity treatments including physician services and lab costs)

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:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-262-2363. You may also contact your state insurance department, 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

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 1-800-442-4123. Additionally, a consumer assistance program can help you file your appeal. Contact 1-800-442-4123. 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 the ExxonMobil Medical Plan and for each administrator go to: www.exxonmobilfamily.com

Does this plan provide Minimum Essential Coverage? [No]

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does not provide minimum essential coverage.

Does this plan meet the Minimum Value Standards? [Yes]

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al1-800-262-2363

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.

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)

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	**$7540**

In this example, Peg would pay: This condition is not covered by this plan, 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	**$7540**

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

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	**$5400**

In this example, Joe would pay: This condition is not covered by this plan, 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	**$5400**

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

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	**$3100**

In this example, Mia would pay: This condition is not covered by this plan, 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	**$3100**

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