# ExxonMobil Medical Plan (EMMP)

# Cigna Open Access Plus-In Network Plan Option (Cigna Option)

# Benefits Information Booklet

**Effective As of January 2014**

*All services, plans and benefits are subject to and governed by the terms (including exclusions and limitations) of the agreement between Cigna Health and Life Insurance Company and ExxonMobil Medical Plan (EMMP). The information herein is believed accurate as of the date of publication and is subject to change without notice.*

*In determining your specific benefits, the full provisions of the formal plan documents, as they exist now or as they may exist in the future, govern. Part 3 of the EMMP formal plan document is intended as the sole document that sets out the benefits provided through the Cigna Open Access Plus-In Network Plan Option. You may obtain copies of these documents by making a written request to the Administrator-Benefits. ExxonMobil reserves the right at any time to change in any way or terminate any benefit.*

*This benefits booklet covers the major features of the Cigna Option administered by Cigna Health and Life Insurance Company. This plan description has been designed to provide a clear and understandable summary of the EMMP Cigna Option and with the Provider/Pharmacy directory serves as the Summary Plan Description (SPD) required for plans subject to ERISA.*

*The Cigna Option administered by Cigna Health and Life Insurance Company is self-insured. There is no insurance company to collect premiums or underwrite coverage. Instead, contributions from you and ExxonMobil pay all benefits. Prior claims experience and forecasted expenses are used to estimate the amount of money needed to pay future benefits. This option is governed by federal laws, not state insurance laws.*

*Applicability to represented employees is governed by collective bargaining agreements and any local bargaining agreements.*

# How To Use Your Benefits Information Booklet

This booklet is your guide to the benefits available through the ExxonMobil Medical Plan Cigna Open Access Plus-In Network (OAPIN) Option (Cigna or Cigna Option), administered by Cigna Health and Life Insurance Company (CHLIC). Please read it carefully and refer to it when you need information about how the Cigna OAPIN Option works, to determine what to do in an emergency situation, and to find out how to handle service issues. It is also an excellent source for learning about many of the special programs available to you as a plan participant.

If you cannot find the answer to your question(s) in the booklet, call the Member Services toll-free number on your ID card.

***Tips for New Plan Participants***

- Keep this booklet where you can easily refer to it.
- Keep your ID card(s) in your wallet.
- Keep your Primary Care Physician's name and number readily accessible.
- Emergencies are covered anytime, anywhere, 24 hours a day.

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# Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE FUNDED BY CONTRIBUTIONS MADE BY PARTICIPANTS AND PARTICIPATING EMPLOYERS RESPONSIBLE FOR BENEFIT PAYMENTS. CIGNA HEALTH AND LIFE INSURANCE COMPANY (CHLIC) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE CIGNA OAPIN Option, BUT CHLIC DOES NOT INSURE THE BENEFITS DESCRIBED.

The Cigna Open Access Plus-In Network (OAPIN) option provides an advantage over other Cigna HMO options by allowing participants to visit any Cigna network provider regardless of service area.

Cigna offers access to care from participating physicians and facilities, with low out-of pocket expenses. You choose a Primary Care Physician (PCP) to coordinate your care, and pay only a co-payment for most services. You don't have to complete a claim form.

You'll get the highest reimbursement level of benefits as long as you visit physicians and facilities in the Cigna network. And that's easy to do, because your PCP should refer you to an in-network specialist or hospital when and if you need one.

References in this document to "Cigna" refer to Cigna Health and Life Insurance Company (CHLIC), a subsidiary of Cigna Corporation.

## Information Sources

When you need information, you may contact:

**Phone Number:**
Cigna Customer Service
800-818-9440
Available 24 hours a day, 7 days a week

**Address:**
Cigna
P. O. Box 182223
Chattanooga, TN 37422-7223

You can search for network providers through Cigna.com or by logging into MyCigna.com.

# Eligibility and Enrollment

## Eligibility

Most U.S. dollar payroll regular employees of Exxon Mobil Corporation and participating affiliates who work at a location where the Medical Plan Cigna OAPIN Option is offered and reside in the service area are eligible for this Cigna OAPIN Option. The employee's home address zip code is used to determine whether the employee resides in the service area and is therefore eligible for the Cigna OAPIN.

Generally you are eligible if:

- You are a regular employee.
- You are an extended part-time employee.
- You are a retiree and not eligible for Medicare Parts A or B.
- You are a survivor, which means an eligible family member of a deceased regular or extended part-time employee or retiree, and not eligible for Medicare Parts A or B.

You are not eligible if:

- You participate in any other employer medical plan to which ExxonMobil contributes.
- You fail to make any required contribution toward the cost of the Medical Plan.
- You fail to comply with general administrative requirements including but not limited to enrollment requirements.
- You lost eligibility as described under the Loss of Eligibility section on page 46.

### *Eligible Family Members*

You may also elect coverage for your eligible family members including:

- Your spouse. When you enroll your spouse for coverage, you may be required to provide proof that you are legally married.
- Your child(ren) under age 26. Coverage ends at the end of the month in which they reach age 26. If your situation involves a family member other than your biological or legally adopted child, call Benefits Administration.
- Your totally and continuously disabled child(ren) who is incapable of self-sustaining employment by reason of mental or physical disability that occurred prior to otherwise losing eligibility and meets the Internal Revenue Service's definition of a dependent.
- A child or spouse of a Medicare-eligible retiree or survivor enrolled in the ExxonMobil Medicare Supplement Plan, as long as that spouse or child is not eligible for Medicare.

More complete definitions of Eligible Family Members and Child appear in the Definitions section of this booklet and in the definition of Qualified Medical Child Support Order.

# Eligibility and Enrollment

### *Suspended Retiree*

A person who becomes a retiree due to incapacity within the meaning of the ExxonMobil Disability Plan and who begins long-term disability benefits under that plan, but whose benefits stop because the person is no longer incapacitated, is a suspended retiree and not eligible for coverage until the earlier of the date the person:

- Reaches age 55; or
- Begins his or her benefit under the ExxonMobil Pension Plan at which time the person is again considered a retiree and may enroll.

The eligible family members of a deceased suspended retiree will be eligible for coverage under this Cigna OAPIN Option only after the occurrence of the earlier of the following:

- The date the suspended retiree would have attained age 55; or
- The date a survivor begins receiving a benefit due to the suspended retiree's accrued benefit from the ExxonMobil Pension Plan.

### *Special Eligibility Rules*

A person who otherwise is not a spouse but who, as a dependent of a former Mobil employee who participated in or received benefits under a Mobil-sponsored plan or program prior to March 1, 2000, is considered an eligible family member as long as that person's eligibility for coverage as a dependent under a Mobil-sponsored plan would have continued.

### *Classes of Coverage*

You can choose coverage as an:

- Employee or retiree only;
- Employee or retiree and spouse;
- Employee or retiree and child(ren); or
- Employee or retiree and family.

There are also classes of coverage for extended part-time employees, surviving spouses and family members of deceased employees and retirees, spouses and family members of retirees covered by the ExxonMobil Medicare Supplement Plan, and employees on certain types of leave of absence.

Each class of coverage described in this section has its own contribution rate. Employees contribute to the Medical Plan through monthly deductions from their pay on a pre-tax or after-tax basis. Retirees and survivors receiving monthly benefit checks from ExxonMobil pay by deductions from these checks on an after-tax basis. Other retirees or survivors and participants with continuation coverage pay by check or by monthly draft on their bank account.

# Eligibility and Enrollment

For employees on an approved leave of absence, their contribution rate will change from the employee contribution rate to the Leave of Absence contribution rate as shown in the table below.

| | Leave of Absence Contribution Rate begins | | |
|---|---|---|---|
| **Type of Leave** | **Immediately** | **No later than after 6 months** | **No later than after 12 months** |
| Military (voluntary) | X | | |
| Civic Affairs | X | | |
| Health / Dependent Care | | X | |
| Education | | X | |
| Personal | | | X |

### *Double Coverage*

No one can be covered more than once in the Medical Plan. You and your spouse cannot both enroll as employees (or retirees) and elect coverage for each other as eligible family members. If you and your spouse work for the company or are both retirees you may both be eligible for coverage. Each of you can be covered as an individual, or one of you can be covered as the employee (or retiree) and the other can be an eligible family member. Also, if you have children, each child can only be covered by one of you.

In addition, a marriage between two ExxonMobil employees does not allow enrollment or cancellation in any of the ExxonMobil health plans if either employee is then making contributions on a pre-tax basis. In order to change your coverage, you need to wait until you experience a change in status that allows coverage changes or Annual Enrollment.

# Eligibility and Enrollment

## Enrollment

### *How to Enroll*

As a newly hired employee, if you complete your enrollment in the Medical Plan within 30 days of your start date, coverage begins the first day of employment. If you enroll between 31 and 60 days from your date of hire, coverage will be effective the first day of the month following receipt of the forms by Benefits Administration. If you enroll in the Cigna OAPIN option, your eligible family members can only enroll in this option.

If you are eligible for the ExxonMobil Pre-Tax Spending Plan, you will be enrolled to pay your monthly contributions on a pre-tax basis unless you annually decline this feature. Your monthly pre-tax contributions and class of coverage must remain in effect for the entire plan year, unless you experience a change in status. (See the Changing Your Coverage section on page 11.)

As a current employee, if you are not covered by a medical plan to which ExxonMobil contributes and elect to enroll in the Medical Plan other than during annual enrollment, you may do so but all of your contributions through the end of the current calendar year will be on an after-tax basis unless you have a subsequent change in status which will allow you to enroll in the ExxonMobil Pre-Tax Spending Plan. Coverage is effective the first of the month following completion of enrollment via EDA or receipt of forms by Benefits Administration.

As an employee, you can enroll eligible family members only if you are enrolled in an ExxonMobil Medical Plan (Medical Plan) option or as a retiree in either the ExxonMobil Medical or in the ExxonMobil Medicare Supplement Plan.

As an employee, you can enroll in a Medical Plan option by using Employee Direct Access (EDA) available on the ExxonMobil Me HR Intranet site. Enrollment forms are also available from Benefits Administration for those individuals who do not have access to EDA. Retirees enroll through the ExxonMobil Benefits Service Center (EMBSC).

You may be requested to provide documents at some future date to prove that the family members you enrolled were eligible (e.g., marriage certificate, birth certificate). If you fail to provide such requested documents within the required time period, coverage for the family members will be cancelled the first of the following month and you may be subject to discipline up to and including termination of employment for falsifying company records.

If you are declining enrollment for yourself or your family members (including your spouse) because of other group health plan coverage, you may enroll yourself and your family members in any available Medical Plan option if you or your family members lose eligibility for that other group health plan coverage (or if the employer stops contributing toward your and/or your family member(s)' other coverage). In addition, you may enroll yourself or your family members in any available Medical Plan option within 60 days after marriage (with coverage effective the first of the following month) or after birth, adoption or placement for adoption (with coverage retroactive to the birth, adoption or placement for adoption).

**CAUTION**: SHOULD YOU DECIDE TO RETROACTIVELY CHANGE TO A DIFFERENT MEDICAL PLAN OPTION, SUCH AS FROM THE CIGNA OAPIN OPTION TO A POS II OPTION, YOUR BENEFITS FOR ANY MEDICAL SERVICES WHICH WERE RECEIVED ON OR AFTER THE EFFECTIVE DATE OF COVERAGE FOLLOWING THE BIRTH, ADOPTION OR PLACEMENT FOR ADOPTION MAY NOT BE COVERED OR MAY BE REIMBURSED AT A LOWER BENEFIT LEVEL. MAKE SURE YOU FULLY UNDERSTAND THE IMPACT OF CHANGING OPTIONS BEFORE MAKING YOUR ELECTION.

# Eligibility and Enrollment

You must enroll each new child for them to be covered, even if you already have family coverage.

Under the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 you may change your Medical Plan election for yourself and any eligible family members within 60 days of either (1) termination of Medicaid or CHIP coverage due to loss of eligibility, or (2) becoming eligible for a state premium assistance program under Medicaid or CHIP coverage. In either case, coverage is effective the first of the month following completion of enrollment or receipt of the forms by Benefits Administration.

### *Annual Enrollment*

Each year, usually during the fall, ExxonMobil offers an annual enrollment period. During this time, you can switch from your current option to another available option. This is also the time to make changes to coverage by adding or deleting family members. Family members may be added or deleted for any reason but they must be deleted if they are no longer eligible. Changes elected during annual enrollment take effect the first of the following year.

NOTE: You should not wait until annual enrollment to delete a family member who loses eligibility; they should be deleted at the time eligibility is lost.

Employees are automatically enrolled in the Pre-Tax Spending Plan to pay monthly contributions on a pre-tax basis unless this feature is declined each time. This choice is only available during the annual enrollment period or with a change in status.

If you pay your monthly contributions on an after-tax basis and would like to continue making contributions on an after-tax basis for the following year, you must elect to do so each year during Annual Enrollment and after each change in status. Otherwise, your contributions will be switched to a pre-tax basis beginning the first day of the following year. As a retiree, you will pay your contributions on an after-tax basis through payroll deduction (if eligible), check, or bank draft.

During Annual Enrollment, changes to your Medical Plan coverage (option or contributions) do not automatically adjust your coverage or contributions to other plans such as the ExxonMobil Dental Plan, ExxonMobil Vision Plan or the flexible spending accounts under the ExxonMobil Pre-Tax Spending Plan. Changes to those plans must be made separately during Annual Enrollment.

# Changing Your Coverage

An employee may add a family member effective the first day of a month if required contributions are made on a pre-tax basis and adding the family member does not change the coverage level **or** if you are enrolled on an after-tax basis, you may make changes to your Medical Plan coverage level (but not your Medical Plan option) and add eligible family members at any time.

To make a change to your coverage you may also wait until Annual Enrollment or until you experience one of the following Changes in Status.

## Changes in Status

This section explains which events are considered changes in status and what changes you may make as a result. If you have a change in status, you must complete your change within 60 days. If you do not complete your change within 60 days, changes to your coverage may be limited. **If you fail to remove an ineligible family member within 60 days of the event that causes the person to be no longer eligible, (e.g., divorce) you must continue to pay the same pre-tax contribution for coverage even though you have removed that ineligible person. The only exception is death of an eligible family member. Your pre-tax contribution for coverage will remain the same until you have another change in status or the first of the plan year following the next annual enrollment period.**

**Important Note:** Your election made due to a change in status cannot be changed after the form is received by Benefits Administration or the transaction is completed in EDA if it changes your pre-tax contributions. If you make a mistake in EDA, call Benefits Administration at 1-800-262-2363 immediately or no later than the same day or first work day following the day on which the mistake was made.

Below is a quick reference guide to the Changes in Status that are discussed in more detail after the table.

| If this event occurs… | You may... |
|---|---|
| Marriage | Enroll yourself and spouse and any new eligible family members or change your Medical Plan Option. |
| Divorce - Employee enrolled in Health Plans. | Change your level of coverage. You must drop coverage for your former spouse but you may not drop coverage for yourself or other covered eligible family members. |
| Divorce - Employee loses coverage under spouse's health plans. | Enroll yourself and other family members who might have lost eligibility for spouse's health plans. |
| Gain a family member through birth, adoption or placement for adoption or guardianship. | Enroll any eligible family members and change Medical Plan Option. |
| Death of a spouse or other eligible family member. | Change your level of coverage. You may not drop coverage for yourself or other covered eligible family members. |
| You or a family member loses eligibility under another employer's group health plan or other employer contributions cease which creates a “HIPAA special enrollment” right. | Enroll yourself and other family members who might have lost eligibility. This only pertains to the Medical Plan. Change your level of coverage and change Medical Plan Option. |

# Changing Your Coverage

| | |
|---|---|
| Other loss of family member's eligibility (e.g., sole managing conservatorship of grandchild ends). | Change your level of coverage. You may not drop coverage for yourself or other eligible family members. |
| You lose eligibility because of a change in your employment status, e.g., regular to non-regular. | Your Medical Plan participation will automatically be termed at the end of the month. |
| You gain eligibility because of a change in your employment status, e.g., non-regular to regular. | Enroll yourself or any eligible family members in Medical Plan. |
| Termination of Employment by spouse or other family member or other change in their employment status (e.g., change from full-time to part-time) triggering loss of eligibility under spouse's or family member's plan in which you or they were enrolled. | Enroll yourself and other family members who may have lost eligibility under the spouse's or family member's plan in Medical Plan and change your Medical Plan Option. |
| Your former spouse is ordered to provide coverage to your children through a QMCSO. | End the family member's coverage, change level of coverage and terminate their participation in Health plans. |
| Commencement of Employment by spouse or other family member or other change in their employment status (e.g., change from part-time to full-time) triggering eligibility under another employer's plan. | End other family member's coverage and terminate their participation in Medical Plan if the employee represents that they have or will obtain coverage under the other employer plan. You may also cancel coverage for yourself, if health care coverage is obtained through your spouse’s employer plan. |
| Change in worksite or residence affecting eligibility to participate in the elected Medical Plan Option (e.g., move out of the Cigna OAPIN service area). | Change your Medical Plan Option and change level of coverage, or drop coverage for yourself or other eligible family members. |
| If you, your spouse, or family member becomes entitled to Medicare or Medicaid. | You may cancel coverage for you or change level of coverage related to the Medicare/Medicaid eligible family member. |
| Judgment, decree or other court order requiring you to cover a family member. (Begin a QMCSO) | Change your Medical Plan Option and change level of coverage. |
| Termination of employment and rehire within 30 days or retroactive reinstatement ordered by court. | Enroll in the same Medical Plans you had prior to termination. |
| Termination of employment and rehire after 30 days | Enroll in Medical Plan as a new hire. |
| You are covered under your spouse's medical plan and plan changes coverage to a lesser coverage level with a higher deductible mid-year. | Enroll yourself and eligible family members in the Health Plans. |
| You begin a leave of absence. | Call Benefits Administration at 1-800-262-2363 to discuss permissible changes. |
| You return from a leave of absence of more than 30 days (paid or unpaid). | Call Benefits Administration at 1-800-262-2363 to discuss permissible changes. |

Changes will only be allowed if the medical/dental/vision enrollment form is received within 60 days of the event by the Benefits Administration Office or the change is made in EDA within 30 days. Unless otherwise noted, the effective date will be the first of the month after the forms are received or the transaction is completed in EDA.

# Changing Your Coverage

***Birth, Adoption or Placement for Adoption***

If you gain a family member through birth, adoption, or placement for adoption you may add the new eligible family member to your current coverage. You may also enroll yourself, your spouse, and all eligible children. You also may change your plan option. Coverage is effective on the date of birth, adoption or placement for adoption. **You must add the new family member within 60 days even if you already have family coverage.** See the Changing your Coverage section for additional circumstances in which changes can be made.

If you enroll your new family member between 31 and 60 days from the birth or adoption and your coverage level changes, you will pay the cost difference on a post-tax basis until the end of the month in which the forms are received by Benefits Administration. Beginning the first day of the following month your deduction will be on a pre-tax basis.

***Sole Legal Guardianship or Sole Managing Conservatorship***

If you (or your spouse, separately or together) become the sole court appointed legal guardian or sole managing conservator of a child and the child meets all other requirements of the definition of an eligible family member, you have 60 days from the date the judgment is signed to enroll the child for coverage. You must provide a copy of the court document signed by a judge appointing you (or your spouse separately or together) guardian or sole managing conservator.

***Marriage***

If you are enrolled in the Medical Plan, you can enroll your new spouse and his or her eligible family members (your stepchildren) for coverage. You also may change your plan option. If you are not already enrolled for coverage, you can sign up for medical coverage for yourself, your new spouse, and your stepchildren. If you gain coverage under your spouse's health plan, you can cancel your coverage. You must make these changes within 60 days following the date of your marriage or wait until Annual Enrollment or another change in status.

***Death of a Spouse***

If you lose coverage under your spouse's health plan, you can sign up for Medical Plan coverage for yourself and your eligible family members. You must make these changes within 60 days following the date you lose coverage or wait until Annual Enrollment or another change in status. If you and your family members are enrolled in the ExxonMobil Medical Plan, any stepchildren will cease to be eligible upon your spouse's death unless you are their court appointed guardian or sole managing conservator.

***When a Child is No Longer Eligible***

If an enrolled family member is no longer an eligible family member, coverage continues through the end of the month in which they cease to be eligible. In some cases, continuation coverage under COBRA may be available. (See page 48 for more details about COBRA.) You must notify and provide the appropriate forms to Benefits Administration as soon as a family member is no longer eligible. If you fail to notify and provide the appropriate forms to Benefits Administration within 60 days, the family member will not be entitled to elect COBRA. While we have an administrative process to remove dependents reaching the maximum eligibility age, you remain responsible for ensuring that the dependent is removed from coverage. If you fail to ensure that a family member is removed in a timely manner, there may be consequences for falsifying company records.

***Divorce***

In the case of divorce, your former spouse and any stepchildren are eligible for coverage only through the end of the month in which the divorce is final. You must notify and provide any requested documents to Benefits Administration as soon as your divorce is final. If you fail to notify and provide the appropriate forms to Benefits Administration within 60 days, the former spouse and family member will not be entitled to elect COBRA. There may also be consequences for falsifying company records. Please see the Continuation Coverage section of this SPD.

# Changing Your Coverage

You may not make a change to your coverage if you and your spouse become legally separated because there is no impact on eligibility.

If you lose coverage under your spouse's health plan because of divorce, you can sign up for medical coverage for yourself and your eligible family members. You must enroll within 60 days following the date you lose coverage under your spouse's plan or wait until Annual Enrollment or another change in status.

***Transfer or Change Residence***

If you move from one location to another, and the move makes you no longer eligible for the selected Medical Plan option (e.g., move out of the OAPIN service area), you may change from your current Medical Plan option to one that is available in your new location. For more information, call Benefits Administration.

***Leave of Absence***

If you are on an approved leave of absence, you can continue coverage by making required contributions directly to the Medical Plan by check. If you chose not to continue your coverage while on leave, your coverage ends on the last day of the month in which your leave began and you will be required to pay for the entire month's contributions. If you fail to make required contributions while on leave, coverage will end.

If the company should make any payment on your behalf to continue your coverage while you are on leave and you decide not to return to work, you will be required to reimburse the company for required contributions.

If you are on an approved leave of absence and the Leave of Absence contribution rate begins, you may continue your coverage by making your required contribution.

If you were on a leave that meets the requirements of the Family and Medical Leave Act of 1993 (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA) and your coverage ended, re-enrollment is subject to FMLA or USERRA requirements.

For more information, call Benefits Administration.

***Change in Coverage Costs or Significant Curtailment***

If the cost for coverage charged to you significantly increases or decreases during a plan year, you may be able to make a corresponding prospective change in your election, including the cancellation of your election. If you choose to revoke your elected coverage option, you may be able to elect coverage under another Medical Plan option. This provision also applies to a significant increase in health care deductible or co-payment.

If the cost for coverage under your spouse's health plan significantly increases or there is a significant curtailment of coverage that permits revocation of coverage during a plan year and you drop that coverage, you will be able to sign up for medical coverage for yourself and your eligible family members. You must enroll within 60 days following the date you lose coverage under your spouse's plan.

# Changing Your Coverage

***Addition or Improvement of Medical Plan Options***

If a new Medical Plan option is added or if benefits under an existing option are significantly improved during a plan year, you may be able to cancel your current election in order to make an election for coverage under the new or improved option.

***Loss of Option***

If a service area under the plan is discontinued, you will be able to elect either to receive coverage under another Medical Plan option providing similar coverage or to drop medical coverage altogether if no similar option is available. For example, if an option is discontinued, you may elect another option that has service in your area or you may elect to participate in the POS II option. You may also discontinue medical coverage altogether.

Remember, if you make your contributions on a pre-tax basis and you experience any of the events mentioned previously, or if you are newly eligible as a result of a change or loss of coverage under your spouse's health plan, it is your responsibility to complete your change within 60 days of experiencing the event. If you miss the 60-day notification period, you will not be able to make changes until Annual Enrollment or until you experience another change in status.

## Other Changes That May Affect Your Coverage

***If a Covered Family Member Lives Away from Home***

Coverage is dependent upon whether the plan option offers service in that area. If your covered family member does not live with you (for instance, you have a child away at school), please contact Member Services to confirm whether service is available. (See service area in Definitions.)

***If You are a Retiree Not Yet Eligible for Medicare***

If you are a retiree, you and your family members who are not eligible for Medicare can continue to participate in the Medical Plan. When you (as a retiree) or a covered family member of a retiree becomes eligible for Medicare, Medicare will become the primary plan for the retiree or other family member and benefits will be coordinated. You then are no longer eligible for the Medical Plan, but you are eligible to enroll in the ExxonMobil Medicare Supplement Plan (EMMSP). If you fail to enroll in the EMMSP when first eligible, then you will not be able to enroll at a later time without proof of having other employer provided coverage immediately prior to enrollment.

***If You Work Beyond When You Become Eligible for Medicare***

If you continue to work for ExxonMobil after you become eligible for Medicare, although you are eligible for Medicare, your ExxonMobil coverage remains in effect for you and eligible family members and the Medical Plan is your primary plan. Medicare benefits, if you sign up for them, will be your secondary benefits.

***If Your Covered Family Members Become Medicare Eligible for Any Reason***

Employees or family members of an employee who become Medicare eligible, either due to age or Social Security disability status, are eligible to participate in any Medical Plan option as long as the employee remains as a regular employee. If the employee retires or dies, Medicare eligible covered family members must change to the ExxonMobil Medicare Supplement Plan and enroll in Medicare Parts A and B. When a retiree or a retiree's covered eligible family member becomes eligible for Medicare, either due to age or Social Security disability status, that person cannot participate in any Medical Plan option but will be eligible for the ExxonMobil Medicare Supplement Plan.

# Changing Your Coverage

***If You are an Extended Part-Time Employee***
If you terminate employment as an extended part-time employee, you are not eligible to continue to participate in the Medical Plan. You may be eligible to elect continuation coverage for yourself and your eligible family members under COBRA provisions. See page 48 for details.

***If You Die***
If you die while enrolled, your covered eligible family members can continue coverage. Their eligibility continues with the company contributions for a specified amount of time:

- If you have 15 or more years of benefit service at the time of your death, eligibility continues until your spouse remarries, becomes eligible for the ExxonMobil Medicare Supplement Plan or dies.
- If you have less than 15 years of benefit service, eligibility continues for twice your length of benefit service or until your spouse remarries, becomes eligible for the ExxonMobil Medicare Supplement Plan, or dies, whichever occurs first.

Children of deceased employees or retirees may continue participation as long as they are an eligible family member. If your surviving spouse remarries, eligibility for your children also ends. Special rules may apply to family members of individuals who become retirees due to disability. See Suspended Retiree below.

Eligible family members of deceased extended part-time employees are not eligible to continue to participate in the Medical Plan. These family members may be eligible to elect continuation coverage under COBRA provisions. See page 48 for details.

***If You Become a Suspended Retiree***
If you are a retiree and you would otherwise lose coverage because you have become a suspended retiree under the ExxonMobil Disability Plan, you may continue coverage for yourself and all your family members who were eligible for Medical Plan participation before you became a suspended retiree for either 12 or 18 months.

Coverage continues for 12 months from the date coverage would otherwise end if you received transition benefits under the ExxonMobil Disability Plan. However, if you did not receive transition benefits under the ExxonMobil Disability Plan, coverage continues for 18 months from the date coverage would otherwise end. The cost of this continued coverage is 102% of the combined participant and company contributions.

# Culture of Health/Partners in Health

Culture of Health is a set of programs and resources to support the overall health of our workforce. The Culture of Health tools and resources include a Health Portal, Health Assessment, and Lifestyle Coaching Program. These programs are available to all eligible employees and family members (age 18 and older) eligible to enroll in the Medical Plan. Retirees who are enrolled in the Medical Plan are also eligible to participate.

Partners in Health is designed to help you improve your health and to assist you in obtaining good health care when care is needed. It reflects a commitment by you and the company to good health and quality care. The Partners in Health tools and resources include a 24 Hour Nurse Line, Health Advocates, Disease Management Programs, Cancer Management Program, and Centers of Excellence.

The tools and resources offered through Culture of Health and Partners in Health are available to you at no additional costs. However, health care claims (e.g., doctor's fees or facilities charges) are processed according to the Medical Plan provisions discussed earlier.

## Health Portal

The Health portal is an Internet Web gateway to reliable health care information reviewed and approved by Healthyroads®. This Internet site is filled with useful health and health care information including the following:

- **Exercise and Nutrition Planners**
- **Test and Procedures Resource** – Short articles providing the latest information about tests and procedures for finding, preventing, and treating health conditions.
- **Wellness Topics** – Provides articles about health and prevention topics at each stage of your life.
- **Tools and Videos** – Easy to use tools and videos to learn more about your health and healthy lifestyle choices.

You may access the Health Portal through the ExxonMobil Family Internet Web Site at www.healthyroads.com/xomcultureofhealth.

## Health Assessment

This online questionnaire, available periodically on the Health Portal, is a quick and easy way to:

- Assess your health status;
- Learn how to maintain your health; and
- Put together a plan to address health risks.

The Healthyroads® Health Assessment can help identify conditions you and your doctor may need to monitor and manage. The assessment is completely confidential, and you may choose to have your results sent to a Health Advocate for review.

# Culture of Health/Partners in Health

## Lifestyle Coaching

Everyone who completes the Health Assessment, whether during the Health Assessment campaign or at any point during the year, will be eligible to enroll in the Healthyroads® Lifestyle Coaching Program. The coaching program is personalized one-on-one support to help you make healthy behavior changes, or to help you maintain the healthy habits you already have. You can work with qualified health coaches on the telephone and use online tools and self-help materials.

## 24-Hour Nurse Line

Trained, licensed nurses are available by telephone, 24 hours a day, 7 days a week to answer routine questions about your health, or questions about a specific medical situation, condition or concern. However, these nurses cannot diagnose medical conditions/ailments, prescribe medication or give specific medical instruction. Topics discussed during your call may include services and expenses not covered under the Plan. The nurse may refer you to a Health Advocate for a more detailed conversation if you face a health risk or serious medical condition.

## Health Advocate Program

The Health Advocate Program provides direct support to you, your family, and your treating physician(s) in the management of specific health care needs. The Health Advocate staff consists of registered nurses, supported by a medical director. Once you begin working with a Health Advocate, the nurse will work personally with you as long as you need support.

Health Advocates will assist you to coordinate a wide array of health care-related support and educational services. As situations require, your Health Advocate will assist you with admission, counseling, inpatient advocacy, discharge planning and home counseling. The nurse will also act as your proactive partner, working directly with you to help you navigate the health care delivery system by assisting with the coordination and management of your health care needs and collaborating with other relevant providers and care managers involved in your treatment. Your Health Advocate could refer you to a Disease Management nurse if you are identified as needing treatment for a disease that is included in the Disease Management Program.

If you or a family member is identified as having an illness or disease or if you have signs or symptoms that indicate that you are at risk for contracting a serious illness or disease and you have primary coverage under the ExxonMobil Medical Plan, the Health Advocates may contact you to provide support, information, and guidance.

## Disease Management Program

If you have certain chronic illnesses and meet certain eligibility criteria, you may be contacted by a licensed registered nurse through the Disease Management Program offered by Alere or you can contact Alere directly at 1-800-557-5519. These specifically trained nurses focus on helping participants with conditions in which education, daily choices, and lifestyle decisions can have a significant effect on health and the progression of the condition. If you elect to work with your disease management nurse, you will receive educational materials, assistance in managing your condition, and personal support. Disease management services are provided for the following primary disease conditions:

- Congestive heart failure
- Coronary artery disease
- Diabetes (adult and pediatric)

- Musculoskeletal and Chronic pain
- Chronic Obstructive Pulmonary Disease (COPD)

## Cancer Management Program

If you are newly diagnosed with cancer, undergoing active treatment for cancer, or are experiencing a recurrence, you may be referred to a specifically trained cancer management nurse through your Health Advocate or Disease Management nurse. Referrals will be made to Alere for support to those undergoing treatment or you can contact Alere directly at 1-800-557-5519.

## Centers of Excellence

Centers of Excellence ("COE") are nationally recognized facilities for the treatment of certain conditions or the delivery of certain procedures where high-level knowledge and expertise provide better care and more likely positive outcomes.

COEs are not available for all diseases and all conditions or procedures relevant to a disease state. For instance, at this time there are COEs for pancreatic cancer, but there is insufficient information available to select COEs for lung cancer. Changes to identified COEs may occur in the future**.** If you would like to learn more about different COE options you will need to contact the 24 hour nurse line who will put you in contact with a Health Advocate who will be able to discuss different options with you.

Participation in a COE program is voluntary, and designed to direct participants to nationally recognized facilities with more positive outcomes. A COE-recommended treatment plan, however, must meet the Medical Plan provisions for medically necessary care in order for claims to be eligible for reimbursement.

Whenever clinically appropriate, you will be referred to a local COE. If access to a clinically appropriate COE requires the patient to travel 75 or more miles, the Medical Plan will reimburse reasonable transportation costs for you and a caregiver. The Medical Plan will also provide a per diem for you and a caregiver to cover lodging and other expenses. If you become hospitalized, only your caregiver will receive the per diem, because food and lodging are already provided as part of the hospital charge. The per diem amounts are established by the Administrator-Benefits.

If you decide not to use a COE, you will not incur additional out-of-pocket costs for choosing another hospital in the Cigna network.

# How this Cigna OAPIN Option Works

To receive In-Network Medical Benefits, services must be provided by a Cigna Network Provider. A Cigna Network Provider is an institution, facility, agency or health care professional, which has contracted directly or indirectly with Cigna. Providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers is located online at www.mycigna.com. The Provider Organization is a network of Participating Providers.

When you enroll, you and each member of your family can select his or her own Primary Care Physician (PCP) from among the physicians in the network. All services must be provided or authorized by your PCP. See the most current listing of participating providers www.mycigna.com. You and your family members may be required to pay a portion of the covered expenses for services and supplies. That portion is the Co-payment**. If you see a doctor who does not participate in the Cigna Network, you'll be responsible for all associated costs.**

If you are unable to locate a Cigna Network Provider in your area who can provide you with a service or supply that is covered under the Cigna OAPIN Option, you must call your PCP to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, those services will be covered at the In-Network benefit level.

## Co-Payments/Deductibles

Co-payments are expenses to be paid by you or your Family Member for the services received. Deductibles are also expenses to be paid by you or your Family Member. Deductible amounts are separate from and not reduced by Co-payments.

## Annual Out-of-Pocket Limit for Prescription Drugs

Once the out-of-pocket maximum has been reached, benefits for Prescription Drugs are payable at 100%.

## Lifetime Maximum Benefit

The total maximum benefit per covered person is unlimited.

## Contract Year

Contract Year means a period from January 1 to December 31 each calendar year.

## Benefits For In-Network Medical Care (including Mental Illness and Substance Abuse, see In-Network Co-Pay Schedule for more information)

- You or your eligible Family Member pays any required Co-payment

**Then**

- This Cigna OPAIN option pays 100% of all services and supplies authorized, as required, by the Primary Care Physician and the Provider Organization

# How this Cigna OAPIN Option Works

## Referrals

Your PCP will provide your primary care and, when medically necessary, your PCP will refer you to other in network doctors or facilities for treatment. The referral is important because it is how your PCP arranges for you to receive necessary, appropriate care and follow-up treatment. Certain services require both a referral from your PCP and prior authorization from Cigna. Once you have obtained verbal approval from your PCP regarding an appropriate referral, inpatient admission or any other service requiring prior authorization, your PCP will coordinate the prior authorization process with Cigna on your behalf. You will not be required, nor expected, to manually track the prior authorization.

## Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from Cigna in order for certain services and benefits to be covered under the Cigna OAPIN Option. Your PCP is responsible for obtaining authorization from Cigna for in-network covered services.

Services that require Prior Authorization include, but are not limited to:

- Inpatient Hospital Services;
- Inpatient Services at any Other Participating Healthcare Facility;
- Outpatient Facility Services;
- Magnetic Resonance Imaging (MRI);
- Nonemergency Ambulance; or
- Organ Transplant Services.
- Mental Health/Substance Abuse Treatment

## Direct Access for Obstetric/Gynecological Services

Females covered by the Cigna OAPIN Option are allowed direct access to a licensed/certified Participating Provider for covered obstetric/gynecological services. There is no requirement to obtain an authorization of care from your Primary Care Physician for visits to a Participating Provider of your choice for pregnancy, well-woman gynecological exams, primary and preventive gynecological care, and acute gynecological conditions. Make sure that the OB/GYN is a Participating Provider prior to each visit and that any services that the OB/GYN requests will be In-Network under the Cigna OAPIN Option.

# In-Network Co-Pay Schedule

| 2014 In-Network Co-Pay Schedule | |
|---|---|
| **In-Network Benefits** | **How this Plan Works** |
| **Physician Services** | |
| Primary Care Physician Office Visit | $25 co-pay, then 100% |
| Routine Physicals & Immunizations (Including Vision and Hearing Exams) | $25 co-pay, then 100% |
| Specialty Care Physician Office Visit | $35 co-pay, then 100% |
| Surgery Performed in the Physician's Office | No charge after the $25 PCP or $35 Specialist per office visit co-pay |
| Allergy Treatment/Injections | No charge after either the office visit co-pay or the actual charge, whichever is less |
| Well-Woman Care (Including Pap Test) | $25 co-pay, then 100% |
| Mammograms | No Charge |
| Prostate Cancer Screening | $25 co-pay, then 100% |
| **Inpatient Hospital - Facility Services** (Bed and Board Daily Limit) | No Charge |
| Semi Private Room and Board | Plan pays the Hospital's negotiated rate |
| Private Room | Plan pays the Hospital's negotiated rate for a semi-private room |
| Special Care Units (ICU/CCU) | Plan pays the Hospital's negotiated rate |
| Operating Room, Recovery Room, Oxygen Anesthesia and Respiratory/Inhalation Therapy | No Charge |
| | |
| **Inpatient Professional Services** | |
| Anesthesiologists | No Charge |
| Radiologists, Pathologists | No Charge |
| Surgeon | No Charge |
| Assistant Surgeon or Co-Surgeon | No Charge |
| Physician Visit | No Charge |
| Nursing Care | No Charge |
| Mastectomy and Breast Reconstruction | No Charge |
| Diagnostic and Therapeutic Laboratory and X-ray | No Charge |
| Hemodialysis | No Charge |
| Radiation Therapy and Chemotherapy | No Charge |
| Organ Transplant Services | No Charge |
| | |
| **Outpatient Facility Services** | |
| Operating Room, Recovery Room, Procedure Room, and Treatment | No Charge |
| | |
| **Outpatient Professional Services** | |
| Anesthesiologists and Respiratory/Inhalation Therapy | No Charge |
| Radiologists, Pathologists | No Charge |
| Surgeon | No Charge |
| Assistant Surgeon or Co-Surgeon | No Charge |
| Physician Visit/Charges for Outpatient Surgery | No Charge |
| Hemodialysis | No Charge |
| Mastectomy and Breast Reconstruction | No Charge |
| Diagnostic and Therapeutic Laboratory and X-ray | No Charge |
| Radiation Therapy and Chemotherapy | No Charge |

# In-Network Co-Pay Schedule

| 2014 In-Network Co-Pay Schedule | |
|---|---|
| **In-Network Benefits** | **How this Plan Works** |
| **Emergency and Urgent Care Services** | |
| Physician's Office | $25 co-pay for Primary Care and $35 co-pay for Specialist, then 100% |
| Hospital Emergency Room | $100 per visit*, then 100%, *Waived if admitted |
| Urgent Care Facility or Outpatient Facility | No charge after $50 per visit copay* |
| Ambulance | No Charge |
| | |
| **Independent Lab Services** | |
| Physician's Office | No Charge |
| Lab Facility | No Charge |
| Hospital Outpatient | No Charge |

| | |
|---|---|
| **Skilled Nursing** | |
| Facility Services | No Charge |
| Skilled Nursing Room and Board | No Charge |
| Contract Year Maximum: 60 Days<br>Also applies to Rehabilitation Hospitals and Sub-Acute Facilities | |
| | |
| **Home Health Care** | No Charge |
| Contract Year Maximum: Unlimited Visits | |
| | |
| **Hospice** | |
| Inpatient | No Charge |
| Outpatient | No Charge per visit |
| | |
| **Rehabilitative Therapy** (including Speech, Occupational, Physical, Chiropractic, Pulmonary, Cardiac and Cognitive Therapy) | |
| Inpatient | Same as Inpatient Hospital Copayment |
| Maximum of 60 visits per contract year for any combination of Therapies | $35 per visit, then 100% |
| | |
| **Maternity** | |
| Pre-Post Delivery Exams: | |
| Initial Visit to Confirm Pregnancy | No charge after the $25 PCP or $35 Specialist per office visit copay; No charge if only x-ray and/or lab services are performed and billed. |
| All Subsequent Visits | No Charge |
| Delivery (Inpatient Hospital, Birthing Center) | Same as plan's Inpatient Hospital Facility benefit |
| | |
| **Family Planning** | |
| Office Visit (Tests) | $25 co-pay for Primary Care and $35 co-pay for Specialist, then 100% |
| Surgical Treatment: Limited to Sterilization Procedures for Vasectomy/Tubal Ligation (excludes Reversals): | $200 co-pay per procedure |
| Inpatient Facility | Same as plan's Inpatient Hospital Facility benefit |
| Outpatient Facility | Same as plan's Outpatient Facility Services benefit |
| Physician's Services | Same as plan's Physician Office co-pay |

# In-Network Co-Pay Schedule

| 2014 In-Network Co-Pay Schedule | |
|---|---|
| **In-Network Benefits** | **How this Plan Works** |
| **Infertility Treatment** | |
| Office Visit including Tests and Counseling | $25 co-pay for Primary Care and $35 co-pay for Specialist, then 100% |
| Surgical Treatment: Limited to procedures for correction of infertility [Excludes In-vitro Fertilization, Artificial Insemination, GIFT (Gamete Intrafallopian Transfer), ZIFT (Zygote Intrafallopian Transfer), etc.] | No charge after $200 surgical co-pay |
| Inpatient Facility | Same as plan's Inpatient Hospital Facility benefit |
| Outpatient Facility | Same as plan's Outpatient Facility Services benefit |
| Physician's Services | Same as plan's Physician's Office co-pay |
| **Durable Medical Equipment** | No Charge |
| Contract Year Maximum: Unlimited | |
| **External Prosthetic Appliances** | $200 deductible, then 100% up to a $1,000 per Contract Year maximum |
| **Vision Care** | |
| Complete Eye Examination - No more than one complete eye exam each in a 12-month period. | $5 co-pay, then 100% |
| Vision Hardware- No more than one pair of eyeglasses or one set of contact lenses in a 12-month period. | |
| Single Lenses<br>Bifocal Lenses<br>Trifocal Lenses<br>Frames<br>Lenticular Lenses<br>Contact Lenses | The plan pays $20 per Contract Year<br>The plan pays $30 per Contract Year<br>The plan pays $40 per Contract Year<br>The plan pays $30 per Contract Year<br>The plan pays $75 per Contract Year<br>The plan pays $75 per Contract Year |
| | |
| **Diabetic Services** | |
| Diabetes Self-Management Courses | Same as office visit Copayment |
| Diabetes Management Medical Equipment - including blood glucose monitors, monitors designed to be used by blind individuals; insulin pumps and associated appurtenances; insulin infusion devices; and podiatric appliances for the prevention of complications associated with diabetes. | No Charge |
| Diabetic Supplies - including test strips for blood glucose monitors, visual reading and urine test strips, lancets and lancet devices, insulin and insulin analogs, injection aids, syringes, prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and glucagon emergency kits. | Same as Prescription Drug Copayment |
| | |
| **Pharmacy Benefits** | |
| • The designation of a prescription drug as Generic, Preferred Brand or Non-Preferred Brand is per generally accepted industry sources and adopted by Cigna. | |
| Retail Prescription Drugs/30 day supply - No coverage for Injectable Infertility Drugs | |
| Generic<br>Preferred Brand<br>Non-Preferred Brand | 20% co-insurance per prescription order or refill<br>30% co-insurance per prescription order or refill<br>45% co-insurance per prescription order or refill<br>The maximum co-pay is $105 per prescription |

# In-Network Co-Pay Schedule

| 2014 In Network Co-Pay Schedule | |
|---|---|
| **In Network Benefits** | **How this Plan Works** |
| Mail Order Drugs/90 day supply - No coverage for Injectable Infertility Drugs | |
| Generic<br>Preferred Brand<br>Non-Preferred Brand | 20% co-insurance per prescription order or refill<br>30% co-insurance per prescription order or refill<br>45% co-insurance per prescription order or refill<br>The maximum co-pay is $155 per prescription |
| Out-of-Pocket Expenses (OOP) for Prescription Drugs - Covered expenses incurred for Prescription Drugs that you pay. Once the out-of-pocket maximum shown below has been reached, benefits for Prescription Drugs are payable at 100% by the Plan. | |
| Out-of-Pocket Maximum*<br>Individual<br>Family<br>*Note that for California residents the out-of-pocket maximum for individual is $3500 and for family $10,500. | <br>$1500<br>$3000 |
| If an employee and one or more eligible family members are covered under this plan, after two eligible family members meet the individual OOP maximum for prescription drugs, then an additional $1,500 must be met by remaining eligible family members to satisfy the Family OOP maximum for prescription drugs. | |

| **Mental Health and Substance Abuse (MH/SA) Benefits** | You and your Eligible Family Member pay any Participating Provider Service Co-payment, **then** the plan pays the Benefit Percentage shown. |
|---|---|
| Mental Illness<br>Inpatient<br>Outpatient<br>Group Therapy | <br>100% covered<br>$25 co-pay per visit, then 100%<br>$25 co-pay per visit, then 100% |
| Substance Abuse<br>Inpatient<br>Outpatient<br>Group Therapy | <br>100% covered<br>$25 co-pay per visit, then 100%<br>$25 co-pay per visit, then 100% |

# In-Network Co-Pay Schedule

## Benefit Percentage/Maximums

If you or any one of your Eligible Family Members, while covered, incurs Covered Expenses described below, Cigna will pay an amount determined as follows for the Covered Expenses, after deducting the applicable Participating Provider Service Co-payment shown in The In-Network Co-Pay Schedule:

- 100% of the Covered Expenses incurred for charges for Emergency Services, provided that:
  a) the Emergency Services are received from or pre-authorized by the person's Primary Care Physician; or
  b) the Emergency Services are not pre-authorized, but are authorized by the Provider Organization after receipt of timely notice, within 48 hours of admission in the case of Hospital Confinement or as soon as reasonably possible. Before benefits are payable, the applicable Emergency Care Co-payment shown in The In-Network Co-Pay Schedule will be deducted from such Covered Expenses, except that the Emergency Room Co-payment will be waived if the person becomes Confined in a Hospital due to that Injury or Sickness:
    - 100% of any other Covered Expenses incurred for charges made by, or authorized care arranged by, a Participating Provider.
    - 100% of the expenses for mental health and substance abuse treatment
    - 100% of the expenses incurred for vision, hearing and speech screenings provided by the Primary Care Physician for persons age 17 and under.
    - 100% of the expenses incurred for charges made by a Participating Provider for any Vision Care listed in The In-Network Co-Pay Schedule, including basic vision screening, refraction, and tono-metric testing as part of a complete eye examination, but not to exceed the Maximum shown in the In-Network Co-Pay Schedule for such care.
    - 100% of the expenses incurred for charges made by a Participating Provider for: (a) routine care of a newborn child prior to discharge from the Hospital nursery; (b) routine physical examinations; and (c) immunizations.

No Cigna OAPIN option benefits are payable unless the services or supplies are Covered Expenses recommended by and received from, or approved by, Participating Providers and are authorized by the person's Primary Care Physician and the Provider Organization, except in the case of Emergency Services. For Emergency Services from non-participating providers, participants must submit a claim no later than 60 days after the first Emergency Service is provided or as soon as reasonably possible. The claim should contain an itemized statement of treatment, expenses, and diagnosis. In the case of mental illness or substance abuse treatment, other than Hospital Confinement solely for detoxification, authorization by the Primary Care Physician will be waived.

# Covered Expenses and Limitations

## Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a covered person for the charges listed below. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician and are essential for the necessary care and treatment of an Injury or Sickness. For expenses incurred for such charges to be considered Covered Expenses, the services or supplies provided must be Medically Necessary.

No Cigna OAPIN Option benefits are payable unless the services or supplies are Covered Expenses recommended by and received from, or approved by, Participating Providers and are authorized by the person's Primary Care Physician and the Provider Organization, except in the case of Emergency Services. For Emergency Services from non-participating providers, participants must submit a claim no later than 60 days after the first Emergency Service is provided or as soon as reasonably possible. The claim should contain an itemized statement of treatment, expenses, and diagnosis. In the case of mental illness or substance abuse treatment, other than Hospital Confinement solely for detoxification, authorization by the Primary Care Physician will be waived.

- Charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Daily Limit shown in the In-Network Co-Pay Schedule.
- Charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- Charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- Charges made by a Free-standing Surgical Facility, on its own behalf, for medical care and treatment.
- Charges made for infertility Treatment for testing, counseling and surgical treatment, but limited to procedures for correction of infertility. [In-vitro Fertilization, Artificial Insemination, GIFT (Gamete Intrafallopian Transfer), ZIFT (Zygote Intrafallopian Transfer), etc. are excluded.]
- Charges made by a Skilled Nursing Facility, on its own behalf, for medical care and treatment; except that for any day of Skilled Nursing Facility confinement, Covered Expenses will not include that portion which is more than the Skilled Nursing Facility Limit shown in the In-Network Co-Pay Schedule; nor will benefits be payable for more than the maximum number of days shown in the In-Network Co-Pay Schedule. Benefits for Rehabilitative Hospitals and Sub-Acute Facilities are also included.
- Charges made by a facility licensed to furnish mental health services, on its own behalf, for care and treatment of mental illness provided on an inpatient or outpatient basis.
- Charges made by a facility licensed to furnish treatment of alcohol and drug abuse, on its own behalf, for care and treatment provided on an inpatient or outpatient basis.
- Charges made by a Physician or a Psychologist for professional services.
- Charges made by a Nurse, other than a member of your family or your Eligible Family Member's family, for professional services.
- Charges made for Emergency Services and Urgent Care.
- Charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration; formulas for PKU, Maple Disease, Histidinemia or Homocystinuria; and therapy provided by a licensed physical, occupational or speech therapist.
- Charges made for the purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from misuse are your responsibility. Durable Medical Equipment is defined as items which are designed for and able to

withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, wheel chairs, and dialysis machines. Durable Medical Equipment items **not** covered, include but are not limited to those listed on the next page.

- **Bed related items**: bed trays, over the bed tables, bed wedges, custom bedroom equipment, non-power mattresses, pillows, posturepedic mattresses, low air mattresses (powered), alternating pressure mattresses.
- **Bath related items**: bath lifts, non-portable whirlpool, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, spas.
- **Chairs, Lifts and Standing Devices**: computerized or gyroscopic mobility systems, roll about chairs, geri chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized - manual hydraulic lifts are covered if the patient is two-person transfer), vitrectomy chairs, auto tilt chairs and fixtures to real property (ceiling lifts, wheelchair ramps, automobile lifts customizations).
- **Air quality items**: room humidifiers, vaporizers, air purifiers, electrostatic machines.
- **Blood/injection related items**: blood pressure cuffs, centrifuges, nova pens, needle-less injectors.
- **Pumps**: back packs for portable pumps.
- **Other equipment**: heat lamps, heating pads, cryo-units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adapters, Enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, exercise equipment, diathermy machines.

- Charges made for or in connection with approved organ transplant services, including immunosuppressive medication; organ procurement costs; and donor's medical costs. The amount payable for donor's medical costs will be reduced by the amount payable for those costs from any other plan. Certain transplants will not be covered based on General Limitations. Contact Cigna before you incur any such costs.
- Charges for the purchase, maintenance or repair of internal prosthetic medical appliances consisting of permanent or temporary internal aids and supports for defective body parts; specifically intraocular lenses, artificial heart valves, cardiac pacemakers, artificial joints, intrauterine devices and other surgical materials such as screw nails sutures, and wire mesh; excluding all other prostheses.
- Charges for external breast prostheses incidental to a mastectomy (the Co-payments and Maximums for external prostheses do not apply to breast prostheses).
- Charges made for the initial purchase and fitting of external prosthetic devices ordered or prescribed by a Physician which are to be used as replacements or substitutes for missing body parts and are necessary for the alleviation or correction of Sickness, Injury or congenital defect. External prosthetic devices shall include:
  - Basic limb prosthetics; terminal devices such as hands or hooks; braces and splints; non-foot orthoses. Only the following nonfoot orthoses are covered: (a) rigid and semirigid custom fabricated orthoses, (b) semirigid prefabricated and flexible orthoses; and (c) rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
  - Custom foot orthotic. Custom foot orthotics are only covered as follows:
    (a) For covered persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease).
    (b) When the foot orthotic is an integral part of a leg brace and it is necessary for the proper functioning of the brace.
    (c) When the foot orthotic is for use as a replacement or substitute for a missing part of the foot (e.g. amputation) and is necessary for the alleviation or correction of illness, injury, or congenital defect.
    (d) For covered persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

  The following are specifically excluded:
  - External power enhancements or power controls for prosthetic limbs and terminal devices;
  - Orthotic shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers; and
  - Orthoses primarily used for cosmetic rather than functional reasons.
  - Replacement and repair of external prosthetic appliances is covered only when required due to reasonable wear and tear and/or anatomical change. All maintenance and repairs that result from the covered person's misuse are the covered person's responsibility.

- Charges made for Home Health Care Services when you; (a) require skilled care; (b) are unable to obtain the required care as an ambulatory outpatient; and (c) do not require confinement in a Hospital or Other Health Care Facility. Home Health Care Services are provided only if Cigna has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for non-skilled care (e.g., bathing, eating, toileting), Home Health Services will only be provided for you during times when there is a family member or care giver present in the home to meet your non-skilled care needs. Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Professionals. A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Eligible Family Member's family or who normally resides in your house or your Eligible Family Member's house even if that person is an Other Health Professional. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-Term Rehabilitative Therapy Maximum shown in the In-Network Co-Pay Schedule.
- Covered Expenses do not include charges made by a Home Health Care Agency for: (a) care or treatment which is not stated in the Home Health Care Plan; (b) the services of a person who is a member of your family or your Eligible Family Member's family or who normally lives in your home or your Eligible Family Member's home; or (c) a period when a person is not under the continuing care of a Physician.
- Charges made for varicose veins surgery when medically necessary.
- Charges made for you or a covered family member who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program: (a) by a Hospice Facility for Bed and Board and Services and Supplies, except that, for any day of confinement in a private room, Covered Expenses will not include that portion of charges which is more than the Hospice Bed and Board Limit shown in the In-Network Co-Pay Schedule; (b) by a Hospice Facility for services provided on an outpatient basis; (c) by a Physician for professional services; (d) by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling, including bereavement counseling within one year after the person's death; (e) for pain relief treatment, including drugs, medicines and medical supplies; (f) by a Home Health Care Agency for: part-time or intermittent nursing care by or under the supervision of a Nurse; or part-time or intermittent services of a Home Health Aide; (g) physical, occupational and speech therapy; and (h) medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the Cigna OAPIN Option if the person had remained or been Confined in a Hospital or Hospice Facility.
  - The following charges for Hospice Care Services are not included as Covered Expenses:
    - For the services of a person who is a member of your family or your Eligible Family Member's family or who normally resides in your house or your Eligible Family Member's house;
    - For any period when you or your Eligible Family Member is not under the care of a Physician;
    - For services or supplies not listed in the Hospice Care Program;
    - For any curative or life-prolonging procedures;
    - To the extent that any other benefits are payable for those expenses under the Cigna OAPIN Option;
    - For services or supplies that are primarily to aid you or your Eligible Family Member in daily living;
    - For more than three bereavement counseling sessions;
    - For services for respite care; or
    - For nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals.

# Covered Expenses and Limitations

Charges made for Mental Health and Substance Abuse Services:

- **Mental Health Services** are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.
- **Substance Abuse** is defined as the psychological or physical dependence on alcohol or other mind-altering drugs requiring diagnosis, care, and treatment. To determine benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse.
- **Inpatient Mental Health Services** are services provided by a facility designated for the treatment and evaluation of Mental Illness. In lieu of hospitalization and upon authorization by Cigna, coverage can be provided in a participating Psychiatric Day Treatment Center, Crisis Stabilization Unit, or Residential Treatment Center for Children and Adolescents.
- **Outpatient Mental Health Services** are services of participating providers qualified to treat Mental Illness on an outpatient basis for treatment of conditions such as: anxiety or depression interfering with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; acute exacerbation of chronic mental illness (crisis intervention and relapse prevention). Coverage will also be provided for outpatient testing and assessment as authorized.
- **Adjunctive Group Therapy** can be utilized for treatment of depression, stress, phobia or other emotional disorders as authorized.
- **Inpatient Substance Abuse Rehabilitation Services** are services provided In-Network for rehabilitation, while you or your eligible Family Member are Confined in a Hospital, requiring diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Partial Hospitalization sessions.
- **Outpatient Substance Abuse Rehabilitation Services** are services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your eligible Family Member is not confined in a Hospital, including outpatient rehabilitation in an individual, group, structured group or in a Substance Abuse Intensive Outpatient Structured Therapy Program. A Substance Abuse Outpatient Structured Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed substance abuse program. Intensive Outpatient Structured Therapy programs provide a combination of individual, family and/or group therapy.
- **Substance Abuse Detoxification Services** are detoxification and related medical ancillary services provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.
- **Mental Health and Substance Abuse Services Exclusions** - The following are specifically excluded from Mental Health and Substance Abuse Services:
  - Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this plan.
  - Treatment of medical disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
  - Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
  - Counseling for activities of an educational nature.
  - Counseling for borderline intellectual functioning.
  - Counseling for occupational problems.

- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.
- Residential treatment.
- Custodial care, including but not limited to geriatric day care.
- Psychological testing on children requested by or for a school system.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.
- Other limitations are shown in the "General Limitations" section.

- Charges made for Infertility Services, including services related to the diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed.
  - **Infertility Services** include approved surgical and medical treatment programs that have been established to have a reasonable likelihood of resulting in pregnancy.

  - The following are specifically **excluded** infertility services:
    - infertility drugs;
    - artificial insemination, gamete intrafallopian transfer (GIFT), in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), and variations of these procedures;
    - any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees);
    - a reversal of voluntary sterilization;
    - infertility services when the infertility is caused by or related to voluntary sterilization;
    - cryopreservation of donor sperm and eggs; and
    - any experimental of investigational infertility procedures or therapies.
- Charges made for Short-Term Rehabilitative Therapy that is part of a rehabilitation program which is medically necessary, including physical, speech, occupational, cognitive, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. Services are provided on an outpatient basis are limited to sixty (60) days per Plan Year for any combination of these therapies, but only if significant improvement can be expected. Also included are services that are provided by a Participating chiropractic Physician when provided in an outpatient setting. Services of a chiropractic Physician include the management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function. Such coverage is available only for rehabilitation following injuries, surgery or medical conditions.

  - The following benefit limitations apply to Short-Term Rehabilitative Therapy and Chiropractic Care services:
    - Services which are considered custodial or educational in nature are not covered.
    - Occupational therapy provided only for purposes of enabling performance of the activities of daily living is not covered.
    - Speech therapy is not covered when (a) used to improve speech skills that have not fully developed except when speech is not fully developed in children due to underlying disease or malformation that prevented speech development; (b) intended to maintain speech communication; or (c) not restorative in nature.
  - If multiple outpatient services are provided on the same day they constitute one visit, but a separate Co-payment will apply to the services provided by each provider.
  - Charges made for human organ and tissue transplant services at designated facilities through the United States. All Organ Transplant Services listed below, other than cornea, kidney and autologous bone marrow/stem cell transplants are available when received at a qualified or provisional Cigna Lifesource Organ Transplant Network facility. The transplants that are covered at Participating Provider facilities,

other than a Cigna Lifesource Organ Transplant Network facility are cornea, kidney and autologous bone marrow/stem cell transplants.

- Coverage is subject to the following conditions and limitations:
  - **Organ Transplant Services** include the recipient's medical, surgical and hospital services; inpatient immunosuppressive medications; and costs for organ procurement. Organ Transplant Services are only covered when they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or small bowel/liver.
  - Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary.

- Charges made for travel expenses incurred by you or your covered Family Member for charges for transportation, lodging and food associated with a pre-approved organ/tissue transplant. All expenses must be pre-approved by your Transplant Case Manager. Organ Transplant Travel Benefits are not available for cornea, kidney and autologous bone marrow/stem cell transplants. Benefits for transportation, lodging and food are available to you only if you or your covered Family Member is the recipient of a pre-approved organ/tissue transplant from a Cigna Lifesource Organ Transplant Network Facility; such benefits are not subject to any individual or family deductible shown in the In-Network Co-Pay Schedule. The term recipient is defined to include you or your covered Family Member receiving preapproved transplant-related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Additionally, this benefit is not subject to the Lifetime Maximum Benefit shown in the In-Network Co-Pay Schedule.
  - Travel expenses for the person receiving the transplant will include charges for:
    (1) transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);
    (2) lodging while at, or traveling to and from the transplant site; and
    (3) food while at, or traveling to and from the transplant site.
    (4) By way of example, but not of limitation, travel expenses will not include any charges for:
      (a) transplant travel benefit costs incurred due to travel within 60 miles of your home;
      (b) laundry bills;
      (c) telephone bills;
      (d) alcohol or tobacco products; and
      (e) transportation charges which exceed coach class rates.

    These benefits are only available if you or your Family Member are the recipient of an organ transplant. No benefits are available if you or your Family Member is a donor.

    The charges associated with the items (1), (2) and (3) above will also be considered covered travel expenses for one companion to accompany you. The term companion includes a spouse, family member, legal guardian of you or your Family Member, or any person not related to you, but actively involved as your caregiver.
- Charges made for reconstructive surgery following a mastectomy; benefits include: (a) surgical services for reconstruction of the breast on which surgery was performed; (b) surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance; (c) postoperative breast prostheses; and (d) mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy are covered.
- Charges made for reconstructive surgery or therapy to repair or correct a severe facial disfigurement or severe physical deformity (other than abnormalities of the jaw related to TMJ disorder) provided that (a) the surgery

or therapy restores or improves function; or (b) reconstruction is required as a result of medically necessary non-cosmetic surgery; or (c) the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part including, but not limited to: microtia, amastia, and Poland Syndrome. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by Cigna.

- Nutritional Evaluation and counseling from a Participating Provider is offered when diet is part of the medical management of a documented disease, including morbid obesity.

### Treatment of Last Resort

Under Cigna's clinical review guidelines, experimental and investigational services are not covered, unless such services are authorized as a treatment of last resort by the Administrator-Benefits. However, medically necessary treatment of complications stemming from experimental and investigational services is covered.

In life-threatening situations, experimental or investigational treatment may be considered a covered expense as a treatment of last resort. A person's condition is considered life-threatening if there is a reasonable likelihood that death will result in a matter of months without treatment or that premature death will occur without early treatment. In this case, proposed experimental or investigational treatments will be reviewed by a panel of specialty-matched experts. The review will include factors such as the efficacy of the proposed treatment, the patient's condition, availability and efficacy of other treatments that are approved for the patient's diagnosis, and the prior use of appropriate treatments for the condition.

Treatment of last resort must be authorized by the Administrator-Benefits, and will be based on the fact that the covered person's condition is life-threatening and the treatment is recommended by a panel of specialty-matched physicians chosen to review the treatment.

# Covered Expenses and Limitations

## Expenses Not Covered

Covered Expenses will not include, and no payment will be made for, expenses incurred:

- For Cosmetic Surgery or Therapy. Cosmetic Surgery or Therapy is defined as surgery or therapy performed to improve appearance or self-esteem.
- Any services, except Emergencies, not provided upon the prior written approval of the Cigna Medical Director or rendered by Participating Providers after preauthorization by the Primary Care Physician.
- Care for health conditions, which are required by state or local law to be treated in a public facility.
- Assistance in the activities of daily living, including, but not limited to eating, bathing, dressing, or other custodial or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For hearing aids or examinations for prescription or fitting thereof, except as otherwise specified in this section.
- For or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous course of Dental treatment started within six months of an Injury to sound natural teeth; or (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; or (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery.
- For transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- For routine physical examinations not required for health reasons including, but not limited to, employment, insurance, government license, court-ordered, forensic or custodial evaluations.
- For which benefits are not payable according to the General Limitations section; except that the following will not apply to this section: (a) limitations with respect to a maximum for multiple surgical procedures, an allowable charge for an assistant surgeon or co-surgeon and covered providers being family members; (b) the limitation, if any, with respect to a child under 15 days old; and (c) any certification or second opinion requirements shown in the In-Network Co-Pay Schedule.
- For rehabilitative therapy by a licensed physical, occupational or speech therapist, or chiropractor, on an outpatient basis, which is provided for all conditions more than 60 visits per calendar year.
- For therapy to improve general physical condition if not Medically Necessary, including, but not limited to, routine, long-term chiropractic care, and rehabilitative services which are provided to reduce potential risk factors in patients in which significant therapeutic improvement is not expected.
- For replacement of external prostheses due to wear and tear, loss, theft or destruction; or for any biomechanical external prosthetic devices.
- For penile prostheses, unless Medically Necessary.
- For the following vision care service, by way of example, but not of limitation: services or items related to orthopetics or vision training; magnification vision aids; charges for tinting, antireflective coatings, prescription sunglasses or light sensitive lenses; an eye examination required by an employer as a condition of employment or which an employer is required to provide under a collective-bargaining agreement; any eye exam required by law; safety glasses or lenses required for employment; any non-prescription eyeglasses, lenses or contact lenses.
- For craniosacral therapy, panniculectomy and abdominoplasty, or prolotherapy.
- The limitation with respect to routine eye refraction's in the "General Limitations" section will not apply to coverage for complete eye examinations.
- For temporomandibular joint dysfunction services.
- For bariatric surgery.
- For varicose vein treatment except when medically necessary.
- For or in connection with procedures to reverse sterilization.

- Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic or custodial evaluations.
- For treatment by acupuncture.
- For artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, hearing aids, dentures and wigs.
- For court ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed under the "Covered Expenses" section of this booklet.
- For non-medical ancillary services, including but not limited to vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, work hardening, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- For consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of "Covered Expenses".
- For private Hospital rooms and/or private duty nursing unless determined by Cigna to be Medically Necessary
- For membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- For amniocentesis, ultrasound, or any other procedures requested solely for gender determination of a fetus, unless Medically Necessary to determine the existence of a gender -linked genetic disorder.
- For genetic testing and therapy including germ line and somatic unless determined Medically Necessary by Cigna for the purpose of making treatment decisions.
- For fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in Cigna's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- For blood administration for the purpose of general improvement in physical condition.
- For the cost of biologicals that are immunizations or medications for the purpose of the travel, or to protect against occupational hazards and risks.
- For cosmetics, dietary supplements, health and beauty aids and nutritional formulae. However, nutritional formulae are covered when required for: (a) the treatment of inborn errors of metabolism or inherited metabolic disease (including disorders of amino acid and organic acid metabolism); or (b) enteral feeding for which the nutritional formulae under state or federal law can be dispensed only through a Physician's prescription, and are Medically Necessary as the primary source of nutrition.
- For personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- For Treatment/surgery of mandibular or maxillary prognathism, microprognathism or malocclusion, surgical augmentation for orthodontics, or maxillary constriction.
- For all noninjectable prescription drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in the "Covered Expenses" section of this booklet.
- For Infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, artificial insemination, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs is also excluded from coverage.
- For which benefits are not payable according to the "General Limitations" section.
- For rhinoplasty

## Prescription Drug Benefits

If you or any one of your Family Members, while covered for these benefits, incurs expenses for charges made by a Participating Pharmacy for Prescription Drugs for an Injury or a Sickness, Cigna will pay that portion of the expense remaining after you or your Family Member has paid the required Co-payment shown in the In-Network Co-Pay Schedule.

Covered expenses will include only Medically Necessary Prescription Drugs and Related Supplies.

Covered charges will include those Prescription Drugs lawfully dispensed upon the written prescription of a Participating Physician or licensed Dentist, at a Participating Pharmacy. Coverage for Prescription Drugs is subject to a Co-payment. The Co-payment amount will never exceed the cost of the drug.

Benefits include coverage of insulin, insulin needles and syringes, glucose test strips and lancets.

If you or any one of your Family Members, while covered for these benefits, is issued a Prescription for a Prescription Drug as part of the rendering of Emergency Services and the prescription cannot reasonably be filled by a Participating Pharmacy, such prescription will be covered as if filled by a Participating Pharmacy.

### *Limitations*

Each prescription drug order or refill will be limited as follows:

- Up to a consecutive thirty (30)-day supply at a Participating Retail Pharmacy, unless limited by the drug manufacturer's packaging;
- Up to a consecutive ninety (90)-day supply at a Participating Mail-Order Pharmacy, unless limited by the drug manufacturer's packaging;
- If two or more prescriptions or refills are dispensed at the same time a Co-payment must be paid for each prescription order or refill;
- When a treatment regimen contains more than one type of drug and the drugs are packaged together for the convenience of the covered person, a co-insurance will apply to each type of drug; or
- To a dosage limit as determined by the Cigna HealthCare Pharmacy and Therapeutics Committee.
- For maintenance medications, as determined by OAPIN, and generally drugs taken on a regular basis to treat ongoing conditions, OAPIN will provide coverage for two fills at a retail pharmacy. For additional refills, these maintenance medications will only be covered when members use Cigna Home Delivery Pharmacy.
- OAPIN will also apply, step therapy (prior authorization program) rules for certain medications as identified by OAPIN. Individuals affected by these rules will be contacted directly by Cigna.

### *Exclusions*

No payment will be made for the following expenses:

- Drugs or medications available over-the-counter for which state or federal laws do not require a prescription or medication that is equivalent (in strength, regardless of form) to an over the counter drug or medication.
- Injectable drugs or medicines, including injectable infertility drugs other than injectables included on the Formulary, used to treat diabetes, acute migraine headaches, anaphylactic reactions, vitamin deficiencies and injectables used for anticoagulation. However, upon prior authorization by Cigna, injectable drugs may be covered subject to the required Co-payment;
- Any drugs that are labeled as experimental or investigational.
- Food and Drug Administration (FDA) approved prescription drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the

standard reference compendia (The United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal.

- Prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than syringes used in conjunction with injectable medications and glucose test strips.
- Prescription drugs or medications used for treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy and decreased libido.
- Prescription vitamins (other than prenatal vitamins), dietary supplements and fluoride products, except for formulas prescribed by a Participating Physician as necessary for the treatment of phenylketonuria or similar inheritable diseases that may cause or result in mental or physical retardation.
- Prescription drugs used for cosmetic purposes such as: drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products.
- Diet pills or appetite suppressants (anorectics).
- Prescription smoking cessation products above the dosage limit as determined by Cigna HealthCare Pharmacy and Therapeutics Committee.
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
- Replacement of Prescription Drugs due to loss or theft.
- Medications used to enhance athletic performance.
- Medications which are to be taken by or administered to a participant while the participant is a patient in a licensed Hospital, skilled nursing facility, rest home or similar institution with a facility dispensing pharmaceuticals on it premises.
- Prescriptions more than one year from the original date of issue.
- A drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee (such as antihistamines).
- All newly FDA approved drugs, prior to review by the Pharmacy and Therapeutics committee.
- Norplant and other implantable contraceptive products.

# Covered Expenses and Limitations

## General Limitations

### *Medical Benefits*

No payment will be made for expenses incurred for you or any one of your Family Members:

- For or in connection with an Injury arising out of, or in the course of, any employment for wage or profit.
- For or in connection with a Sickness which is covered under any workers' compensation or similar law.
- For charges made by a Hospital owned or operated by or which provides care or performs services for the United States Government, if such charges are directly related to a military-service-connected Sickness or Injury.
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which the person is not legally required to pay.
- For charges for unnecessary care, treatment or surgery.
- For or in connection with Custodial Services, education or training.
- To the extent that you or any one of your Family Members is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- For experimental drugs or substances not approved by the Food and Drug Administration, or for drugs labeled: "Caution - limited by federal law to investigational use".
- For or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate medical specialty society.
- For charges made by a Physician for or in connection with surgery which exceed the following maximum when two or more surgical procedures are performed at one time: the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and 1/2 of the amount otherwise payable for all other surgical procedures.
- For or in connection with in vitro fertilization, artificial insemination, GIFT (Gamete Intrafallopian Transfer), ZIFT (Zygote Intrafallopian Transfer), or similar procedures.
- For charges made by an assistant surgeon exceeding 20 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)
- For total charges made by co-surgeons exceeding 62.5% of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)
- For charges made for or in connection with the purchase or replacement of contact lenses except as specifically provided under "Exclusive Provider Medical Benefits"; however, the purchase of the first pair of contact lenses that follows cataract surgery will be covered.
- For charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
- For charges for supplies, care, treatment or surgery which are not considered essential for the necessary care and treatment of an Injury or Sickness, as determined by Cigna.
- For charges made for or in connection with tired, weak or strained feet for which treatment consists of routine footcare, including but not limited to, the removal of calluses and corns or the trimming of nails unless medically necessary.
- For or in connection with speech therapy, if such therapy is (a) used to improve speech skills that have not fully developed; (b) can be considered custodial or educational; or (c) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered.
- For charges made by any covered provider who is a member of your family or your Eligible Family Member's family.

# Covered Expenses and Limitations

- No payment will be made for expenses incurred for you or any one of your Family Members to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:
  - A "no-fault" insurance law; or
  - An uninsured motorist insurance law.
  - Cigna will take into account any adjustment option chosen under such part by you or any one of your Family Members.
- For charges which would not have been made if the person had no insurance;
- To the extent that you or any one of your Family Members is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- For Experimental, Investigational or Unproven Services which are medical, surgical, psychiatric, substance abuse or other healthcare technologies, supplies, treatments, procedures, drug therapies, or devices that are determined by Cigna , to be:
  (a) not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional journal; or
  (b) the subject of review or approval by an Institutional Review Board for the proposed use; or
  (c) the subject of an ongoing clinical trial that meets the definition of a phase I, II, or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or
  (d) not demonstrated, through existing peer-reviewed literature, to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
- For expenses incurred outside the United States or Canada, unless you or your Family Member is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.
- For non-medical ancillary services, including but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety and services, training or educational therapy for learning disabilities, developmental delays, autism or mental retardation.
- For medical treatment when payment is denied by a Primary Group Health Plan because treatment was received from a non-participating provider;
- For charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- For medical and Hospital care and costs for the infant child of an Eligible Family Member, unless that infant child is otherwise eligible under this Cigna OAPIN Option.

# Coordination of Benefits

This section applies if you or any one of your Family Members is covered under more than one group health plan and determines how benefits payable from all such group health plans will be coordinated. You should file all claims with each group health plan.

## Definitions

For the purposes of this section, the following terms have the meanings set forth below:

### *Group Health Plan*

Any of the following that provides benefits or services for medical, dental, or vision care or treatment:

(1) Group insurance and/or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage.
(2) Coverage under Medicare and other governmental benefits as permitted by law accepting Medicaid and Medicare supplement policies. It does not include any plan when benefits are in excess to those of any private insurance program or other non-governmental program.
(3) Medical benefits coverage of group, group-type, and individual "no-fault" and traditional automobile "fault" contracts.

Each Group Health Plan or part of a Group Health Plan which has the right to coordinate benefits will be considered a separate Group Health Plan.

### *Closed Panel Group Health Plan*

A Group Health Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

### *Primary Group Health Plan*

The Group Health Plan that determines and provides or pays benefits without taking into consideration the existence of any other Group Health Plan.

### *Secondary Group Health Plan*

A Group Health Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Group Health Plan. A Secondary Group Health Plan may also recover from the Primary Group Health Plan the Reasonable Cash Value of any services it provided to you.

### *Allowable Expense*

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or co-payments, that is covered in full or in part by any Group Health Plan covering you. When a Group Health Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Prior Mental Health/Substance Abuse Treatment
Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

(1) An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
(2) If you are confined to a private Hospital room and no Group Health Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
(3) If you are covered by two or more Group Health Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
(4) If you are covered by one Group Health Plan that provides services or supplies on the basis of reasonable and customary fees and one Group Health Plan that provides services and supplies on the basis of negotiated fees, the Primary Group Health Plan's fee arrangement shall be the Allowable Expense.
(5) If your benefits are reduced under the Primary Group Health Plan (through the imposition of a higher co-payment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Group Health Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Group Health Plan provisions include second surgical opinions and pre-certification of admissions or services.

### *Claim Determination Period*

A calendar year, but does not include any part of a year during which you are not covered under this Cigna OAPIN Option or any date before this section or any similar provision takes effect.

### *Reasonable Cash Value*

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

### *Order of Benefit Determination Rules*

A Group Health Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Group Health Plan. If the Group Health Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

(1) The Group Health Plan that covers you as an enrollee or an employee shall be the Primary Group Health Plan and the Group Health Plan that covers you as a Eligible Family Member shall be the Secondary Group Health Plan;
(2) If you are a child whose parents are not divorced or legally separated, the Primary Group Health Plan shall be the Group Health Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
(3) If you are the child of divorced or separated parents, benefits for the Eligible Family Member shall be determined in the following order:
    (a) first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Group Health Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
    (b) then, the Group Health Plan of the parent with custody of the child;
    (c) then, the Group Health Plan of the spouse of the parent with custody of the child;
    (d) then, the Group Health Plan of the parent not having custody of the child, and
    (e) finally, the Group Health Plan of the spouse of the parent not having custody of the child.
(4) The Group Health Plan that covers you as an active employee (or as that employee's Family Member) shall be the Primary Group Health Plan and the Group Health Plan that covers you as laid-off or retired employee

(or as that employee's Family Member) shall be the secondary Group Health Plan. If the other Group Health Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(5) The Group Health Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Group Health Plan and the Group Health Plan that covers you as an active employee or retiree (or as that employee's Eligible Family Member) shall be the Primary Group Health Plan If the other Group Health Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(6) If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Group Health Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Group Health Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Cigna OAPIN Option will be the Secondary Group Health Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Group Health Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

### *Effect on the Benefits of this Cigna OAPIN Option*

If this Cigna OAPIN Option is the Secondary Group Health Plan, this Group Health Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than one hundred percent (100%) of the total of all Allowable Expenses.

The difference between the amount that this Cigna OAPIN Option would have paid if this Cigna OAPIN Option had been the Primary Group Health Plan, and the benefit payments that this Cigna OAPIN Option had actually paid as the Secondary Group Health Plan, will be recorded as a benefit reserve for you. Cigna will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

(1) Cigna obligation to provide services and supplies under this Cigna OAPIN Option ;
(2) Whether a benefit reserve has been recorded for you; and
(3) Whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to one hundred percent (100%) of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero (0) and a new benefit reserve shall be calculated for each new Claim Determination Period.

### *Recovery of Excess Benefits*

If Cigna pays charges for benefits that should have been paid by the Primary Group Health Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the plan, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you shall execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

# Coordination of Benefits

***Right to Receive and Release Information***

Cigna, without consent or notice to you, may obtain information from and release information to any other Group Health Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Group Health Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

## Right of Reimbursement

The Cigna OAPIN Option does not cover:

- Expenses for which another party may be responsible as a result of liability for causing or contributing to the injury or illness of you or your Family Member(s).
- Expenses to the extent they are covered under the terms of any automobile medical, automobile no fault, uninsured or underinsured motorist, workers' compensation, government insurance, other than Medicaid, or similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your Family Member(s).

If you or a Family Member incurs health care Expenses as described above, Cigna shall automatically have a lien upon the proceeds of any recovery by you or your Family Member(s) from such party to the extent of any benefits provided to you or your Family Member(s) by the Plan. You or your Family Member(s) or their representative shall execute such documents as may be required to secure Cigna’s rights. Cigna shall be reimbursed the lesser of:

- The amount actually paid by Cigna under the Plan; or
- An amount actually received from the third party;
- At the time that the third party's liability is determined and satisfied; whether by settlement, judgment, arbitration or otherwise.

# Payment of Benefits

## To Whom Payable

At the option of Cigna and with the consent of the Employer, all or any part of medical benefits may be paid directly to the person or institution on whose charge claim is based. Otherwise, medical benefits are payable to you.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, Cigna may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release Cigna from all liability to the extent of any payment made.

## Time of Payment

Benefits will be paid by Cigna when it receives due proof of loss.

## Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

# When Coverage Ends

Coverage for you and/or your family members ends on the earliest of the following dates:

- The last day of the month in which:
  - You terminate employment (except as a retiree or due to disability);
  - You elect to no longer participate;
  - A family member ceases to be eligible (for example, a child reaches age 26);
  - A retiree becomes a suspended retiree;
  - You are no longer eligible for benefits under this Cigna OAPIN Option (e.g., employment classification changes from "regular employee" to "non-regular employee" or from non-represented to represented where you are no longer eligible for this Cigna OAPIN Option );
  - You do not make any required contribution;
  - A Qualified Medical Child Support Order is no longer in effect for a covered family member;
  - You, as a retiree, or your eligible family member becomes eligible for Medicare and for the ExxonMobil Medicare Supplement Plan;

  OR

- The date:
  - You die;
  - The Medical Plan ends;
  - Your employer discontinues participation in the Medical Plan;
  - You enrolled an ineligible family member and in the opinion of the Administrator-Benefits, the enrollment was a result of fraud or a misrepresentation of a material fact.

You are responsible for ending coverage with Benefits Administration when your enrolled spouse or family member is no longer eligible for coverage. If you do not complete your change within 60 days, any contributions you make for ineligible family members will not be refunded.

## Loss of Eligibility

Everyone in your family may lose eligibility for Medical Plan coverage, and you may be subject to disciplinary action up to and including termination of employment if you commit fraud against the Medical Plan, for instance, by filing claims for benefits to which you are not entitled. Coverage may also be terminated if you refuse to repay amounts erroneously paid by the Medical Plan on your behalf or that you recover from a third party. Your participation may be terminated if you fail to comply with the terms of the Medical Plan and its administrative requirements. You may also lose eligibility if you enroll persons who are not eligible, for instance, by covering family members who do meet the eligibility requirements. This includes failing to provide timely notification of when a covered family member loses eligibility, e.g. spouse loses coverage.

## Extended Benefits at Termination

You are entitled to extended coverage for as much as a year if you are terminated due to disability with fewer than 15 years of service. This coverage is provided at no cost to you. This is considered a portion of the COBRA continuation period. In order to assure coverage beyond this extension period, you must elect COBRA upon termination of employment. Several conditions must be met:

- The disability must exist when your employment terminates.
- The extension lasts only as long as the disability continues, but no longer than 12 months.
- This extension applies only to the employee who is terminated because of a disability. Continuation coverage for eligible family members may be available through COBRA.

# When Coverage Ends

## Portability of Coverage

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Benefits Administration will give you a certificate confirming your participation in the Medical Plan when your employment terminates.

# Continuation of Coverage

## Introduction

You are required to be given the information in this section because you are covered under a group health plan (the Medical Plan). This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Medical Plan. This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Medical Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Medical Plan and under federal law, you should review this SPD or contact ExxonMobil Benefits Administration at the telephone numbers or address listed under Benefits Administration on page 52.

IMPORTANT: "Benefits Administration" references throughout this section change depending on your status. Unless specifically stated otherwise, you should refer to Benefits Administration using the list below.

- Current ExxonMobil employees or their family members refer to ExxonMobil Benefits Administration/ Health Plan Services;
- Exxon, or Mobil, or Superior Oil, or ExxonMobil retirees, or their survivors, or their family members refer to ExxonMobil Benefits Service Center; and
- Former Exxon or ExxonMobil employees, or retirees, or their survivors, or their family members who have elected and are participating through COBRA, refer to ExxonMobil COBRA Administration.

The contact information for each of these entities is as shown on page 52.

## What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your children could become qualified beneficiaries if coverage under the Medical Plan is lost because of the qualifying event. Under the Medical Plan, qualified beneficiaries who elect COBRA continuation coverage must pay the entire cost of COBRA continuation coverage.

An employee will become a qualified beneficiary if the employee loses coverage under the Medical Plan because either one of the following qualifying events happens:
- Hours of employment are reduced; or
- Employment ends for any reason other than the employee's gross misconduct.

The spouse of an employee or retiree will become a qualified beneficiary if the spouse loses coverage under the Medical Plan because any of the following qualifying events happens:
- The employee or retiree dies;
- The employee's hours of employment are reduced;
- The employee's employment ends for any reason other than his or her gross misconduct;
- The employee or retiree becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- Divorce.

Children will become qualified beneficiaries if they lose coverage under the Medical Plan because any of the following qualifying events happens:

- The parent-employee or parent-retiree dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee or parent-retiree becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced; or
- The child stops being eligible for coverage under the Medical Plan as a child.

Any retiree, retiree's spouse (including surviving spouse), and children will become qualifying beneficiaries if a proceeding in bankruptcy is filed with respect to Exxon Mobil Corporation, and the bankruptcy results in a loss of coverage.

## When is COBRA Coverage Available?

The Medical Plan will offer COBRA continuation coverage to qualified beneficiaries only after Benefits Administration has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or retiree, or commencement of a proceeding in bankruptcy with respect to the employer, the employer must notify Benefits Administration of the qualifying event.

## You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or a child losing eligibility for coverage), you must notify and provide the appropriate forms to Benefits Administration within 60 days after the later of the date the qualifying event occurs or the date you would lose benefits under the Medical Plan. See page 52 for Benefits Administration contact information. Notices of these qualifying events from current employees must be made by logging onto Employee Direct Access (EDA) located on the ExxonMobil Me HR Intranet site. Forms are also available from ExxonMobil Benefits Administration/Health Plan Services for those individuals who do not have access to EDA. Notice is not effective until either an EDA change is made or the properly completed form is received by Benefits Administration.

## How is COBRA Coverage Provided?

Once Benefits Administration receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees or retirees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or a child losing eligibility, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or the reduction of the employee's hours of employment and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts only up to a

total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

## Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Medical Plan is determined by the Social Security Administration to be disabled and you notify the ExxonMobil Benefits Administration/ Health Plan Services in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify ExxonMobil Benefits Administration/ Health Plan Services. (See page 52 for Benefits Administration contact information.)

You must provide the written determination of disability from the Social Security Administration to Benefits Administration within 60 days of the latest of the date of the disability determination by the Social Security Administration, the date of the qualifying event or the benefit termination date; and prior to the end of the 18-month COBRA continuation period. (See page 52 for Benefits Administration contact information.)

## Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to Benefits Administration. This extension may be available to the spouse and any children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), gets divorced, or if the child stops being eligible under the Plan as a child. This extension is available only if the qualifying event would have caused the spouse or child to lose coverage under the Plan had the first qualifying event not occurred.

## Cost of COBRA Coverage

A person who elects continuation coverage may be required to pay the group rate premium for continuation coverage plus a 2% administration fee, if applicable, or 102% of the cost to the plan to maintain the coverage, unless the person is entitled to extended coverage due to disability. If the person becomes entitled to such extended coverage, the person may be required to contribute up to 150% of contributions after the initial 18-month's coverage until coverage ends. A person who elects continuation coverage must pay the required contributions within 45 days from the date coverage is elected retroactively to the date benefits terminated under the Plan.

# Continuation of Coverage

## If You Have Questions

Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.)

## Keep Your Medical Plan Informed of Address Changes

In order to protect your family's rights, you should keep Benefits Administration informed of any changes in your address as well as the addresses of family members. You should also keep a copy, for your records, of any notices you send to Benefits Administration.

# Continuation of Coverage

## Contacts for COBRA Rights Under the ExxonMobil Medical Plan

The following sets out the contact numbers based on your status under the ExxonMobil Medical Plan. It is your responsibility to contact Benefits Administration with any required notices and address changes. Failure to notify the correct entity could result in your loss of COBRA rights. If your status is not listed, call ExxonMobil Benefits Administration/Health Plan Services for assistance or contact them at hr.medical.dental.questions@exxonmobil.com.

Phone Numbers:

Address:

- Employees call:

  **ExxonMobil Benefits Administration/Health Plan Services**
  Monday - Friday 8:00 a.m. to 3:00 p.m. (U.S. Central Time), except certain holidays

  713-680-5858 (Houston)
  713-680-7070 (international, call collect)
  800-262-2363 (toll free outside Houston)

  **ExxonMobil Benefits Administration**
  **ATTN: Health Plan Services**
  ExxonMobil BA BSC USBA
  4300 Dacoma or "BH1"
  Houston, TX 77092

- Retirees and Survivors call:

  **ExxonMobil Benefits Service Center**
  Monday - Friday 8:00 a.m. to 6:00 p.m. (U.S. Eastern Time), except certain holidays

  800-682-2847
  800-TDD-TDD4 (833-8334) for the hearing impaired

  **ExxonMobil Benefits Service Center**

  P.O. Box 199540
  Dallas, TX 75219-9722

- Former Exxon or ExxonMobil Employees, Exxon or ExxonMobil Retirees, or their Survivor or their Family Members, who elected and are participating through COBRA, call:

  **ExxonMobil COBRA Administration**
  Monday - Friday 8:00 a.m. to 8:00 p.m. (U.S. Central Time), except certain holidays

  800-522-6621
  770- 619-7160 (fax)

  **ADP Benefit Services**
  **ADP National Accounts**
  **ExxonMobil COBRA Administration**
  P.O. Box 2968
  Alpharetta, GA 30023-2968

# Claim Determination Procedures

## Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be medically necessary to be covered under the Plan. The procedures for determining medical necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical necessity determinations are made on either a pre-service, concurrent, or post-service basis, as described below.

Certain services require prior authorization in order to be covered. This prior authorization is called a "pre-service medical necessity determination." This booklet describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care provider) must request medical necessity determinations according to the procedures described below, and in your provider's network participation documents as applicable. When services or benefits are determined to be not medically necessary, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described below, in your provider's network participation documents, and in the determination notices.

### *Pre-Service Medical Necessity Determinations*

When you or your representative request a required medical necessity determination prior to care, Cigna will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would (a) seriously jeopardize your life or health, your ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the pre-service determination on an expedited basis. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative fails to follow Cigna's procedures for requesting a required pre-service medical necessity determination, Cigna will notify you or your representative of the failure and describe the proper procedures for filing within five days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

### *Concurrent Medical Necessity Determinations*

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent medical necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, Cigna will notify you or your representative of the determination within 24 hours after receiving the request.

### *Post-Service Medical Necessity Determinations*

When you or your representative requests a medical necessity determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

## Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; (6) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

# When You Have a Complaint or an Appeal

The following complies with federal law and is for claims submitted on or after January 1, 2003.
For the purposes of this section, any reference to "you," "your," or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

Cigna wants you to be completely satisfied with the care you receive. That is why Cigna has established a process for addressing your concerns and solving your problems.

## Start with Member Services

Cigna is here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call the toll-free number on your Benefit Identification card, explanation of benefits, or claim form and explain your concern to one of our Member Services representatives. You can also express that concern in writing.

Cigna will do their best to resolve the matter on your initial contact. If Cigna needs more time to review or investigate your concern, you will be contacted as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

## Appeals Procedure

Cigna has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to Cigna within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call or write us at the toll-free number on your Benefit Identification card, explanation of benefits, or claim form.

***Level One Appeal***
Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, Cigna will respond in writing with a decision within 15 calendar days after receipt of an appeal for a required pre-service or concurrent care coverage determination, and within 30 calendar days after receipt of an appeal for a post-service coverage determination. If more time or information is needed to make the determination, you will be notified in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

### *Level Two Appeal*

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness the Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals Cigna will acknowledge in writing receipt of your request and schedule a Committee review. For required pre-service and concurrent care coverage determinations the Committee review will be completed within 15 calendar days and for post service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, you will be notified in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician, would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expected, Cigna will respond orally with a decision within 72 hours, followed up in writing.

## Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna Health Care or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this Independent Review Process. Cigna will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna’s level two appeal review denial. Cigna will then forward the file to the Independent Review Organization. The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your condition, as determined by Cigna's Physician reviewer, the review shall be completed within three days.

The Independent Review Program is a voluntary program arranged by Cigna.

# When You Have a Complaint or an Appeal

## Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA within one year of the completion of the appeal if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options. One way to find out what may be available is to contact your local U.S. Department of Labor office. You may also contact the Plan Administrator.

### *Relevant Information*

Relevant information is any document, record or other information which: (a) was relied upon in making the benefit determination; (b) was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; or (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the Cigna OAPIN Option concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

## Legal Action

Since the plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA within one (1) year following the completion of the appeal process if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level One and Level Two appeal processes. If your appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

# Administrative and ERISA Required Information

## Basic Medical Plan Information

### *Plan Name*

ExxonMobil Medical Plan

### *Plan Sponsor and Participating Affiliates*

The ExxonMobil Medical Plan is sponsored by:
Exxon Mobil Corporation
5959 Las Colinas Blvd.
Irving, Texas 75039-2298

All of Exxon Mobil Corporation's divisions and most of the major U.S. affiliates participate in the ExxonMobil Medical Plan. A complete list of participating affiliates is available from the Administrator-Benefits upon written request.

Certain employees covered by collective bargaining agreements do not participate in the plan.

### *Plan Numbers*

The ExxonMobil Medical Plan is identified with government agencies under two numbers:
The Employer Identification Number (EIN), 13-5409005, and the Plan Number (PN), 538.

### *Plan Administrator and Discretionary Authority*

The Plan Administrator of the Medical Plan is the Administrator-Benefits who is the Manager-Global Benefits Design, Exxon Mobil Corporation. The Administrator-Benefits (and those to whom the Administrator-Benefits has delegated authority) has the full and final discretionary authority to determine eligibility for benefits. Various aspects of the Cigna OAPIN Option are administered by Cigna.

The Administrator-Benefits has delegated to Cigna the full and final discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the Cigna Open Access Plus-In Network Option. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the Cigna OAPIN Option, the determination of whether a person is entitled to benefits under the Cigna OAPIN Option, and the computation of any and all benefit payments. The Administrator-Benefits also delegates to Cigna the full and final discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

You may contact the Administrator-Benefits at the following address. Legal process may be served upon the Administrator-Benefits c/o Exxon Mobil Corporation by serving the Corporation's Registered Agent for Service of Process, Corporation Service Company (CSC).

| | |
|---|---|
| **For appeals of eligibility or enrollment issues:**<br>Administrator-Benefits<br>P.O. Box 2283<br>Houston, TX 77252-2283<br><br>**For service of legal process:**<br>Corporation Service Company<br>211 East 7th Street, Suite 620<br>Austin, TX 78701-3218 | Cigna<br><br>***For appeals on benefits issues:***<br>Cigna may be contacted for appeals of benefits issues at an address provided by calling Member Services or as reflected on your Explanation of Benefits. |

# Administrative and ERISA Required Information

### *Type of Plan*

The ExxonMobil Medical Plan is a welfare plan under ERISA providing medical benefits.

### *Plan Year*

The Plan's fiscal year ends on December 31.

### *Collective Bargaining Agreements*

The Medical Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Administrator-Benefits upon written request.

Eligibility for participation in the ExxonMobil Medical Plan by represented Employees is governed by local bargaining requirements.

### *Funding*

The Cigna OAPIN Option, is funded solely through contributions by the Employer and/or Plan Participants. Benefits under the Medical Plan are funded through participant and company contributions. Each year, Exxon Mobil Corporation determines the rates of required participant contributions to the Exxon Mobil Medical Plan. These rates are based on past and projected Cigna OAPIN Option experience. (See self-funded plan in the Definitions section.)

### *Claims Processor*

Cigna is the claims processor and claims fiduciary.

### *No Implied Promises*

Nothing in this booklet says or implies that participation in the ExxonMobil Medical Plan is a guarantee of continued employment with the company.

### *If the ExxonMobil Medical Plan is Amended or Terminated*

The company reserves the right at any time and for any reason to terminate, suspend, withdraw, amend or modify the ExxonMobil Medical Plan or any of its provisions. If any reductions in benefits are made in the future, you will be notified within sixty (60) days of the signing of the amendment. In the event the Cigna OAPIN Option, is terminated, you will have the right to elect continuation coverage, as described in the COBRA section of this booklet, in any other health plan option maintained by Exxon Mobil Corporation or its controlled group.

# Administrative and ERISA Required Information

## Your Rights Under ERISA

As a participant in the ExxonMobil Medical Plan, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

### *Receive Information about Your Plan and Benefits*

Examine, without charge, at the office of the Administrator-Benefits and at other specified locations, such as worksites, and union halls, all documents governing the Medical plan, including contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Medical Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Administrator-Benefits, copies of documents governing the operation of the Medical Plan, including collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may require a reasonable charge for the copies.

Receive a summary of the Medical Plan's annual financial report. The Administrator-Benefits is required by law to furnish each participant with a copy of this Summary Annual Report.

### *Prudent Actions by Plan Fiduciaries*

In addition to creating rights for Medical Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Medical Plan, called "fiduciaries" of the Medical Plan, have a duty to do so prudently and in the interest of you and other Medical Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

### *Enforce Your Rights*

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Medical Plan documents or the latest Summary Annual Report from the Medical Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Administrator-Benefits to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim and an appeal for benefits, which are denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Medical Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in Federal court. Any such lawsuits must be brought within one year of the date on which an appeal was denied. If it should happen that Medical Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

# Administrative and ERISA Required Information

### *Assistance with Your Questions*

If you have any questions about the Medical Plan, you should contact the Plan Administrator. If you have any questions about your rights under ERISA, or if you need assistance in obtaining documents from the Administrator-Benefits, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210**.** You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

# Notice of Federal Requirements

## Grandfathered Plan Intent

Exxon Mobil Corporation believes that most options available under the ExxonMobil Medical Plan (Medical Plan) are "grandfathered health plans" under the Patient Protection and Affordable Care Act (PPACA). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect on March 23, 2010. Grandfathered plan options under the Medical Plan may not include all consumer protections of the Affordable Care Act that apply to other plans. For example, most options under the Medical Plan cover some, but not all, preventive health services without any cost sharing. The benefit option that is not a grandfathered health plan is the Excellus Blue Choice option offered only in the State of New York. The Excellus Blue Choice option under the Medical Plan meets all of the requirements of PPACA.

Questions regarding which protections apply to the Medical Plan and what might cause the Medical Plan or one or more of its options to change from grandfathered health plan status can be directed to the Plan Administrator at Administrator-Benefits**,** P.O. Box 2283, Houston, Texas 77252-2283. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

## Women's Health and Cancer Rights Act

If you have a mastectomy, at any time, and decide to have breast reconstruction, based on consultation with your attending physician, the following benefits will be subject to the same percentage co-payment and deductibles which apply to other plan benefits:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Services for physical complications in all stages of mastectomy, including lymphedema.

The above benefits will be provided subject to the same deductibles, co-payments and limits applicable to other covered services.

If you have any questions about your benefits, please contact Cigna Member Services.

## Coverage for Maternity Hospital Stay

Under federal law, the Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

# Definitions

**Bed and Board**

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

**Benefit Service**

Generally, all the time from the first day of employment until you leave the company's employment.
Excluded are:

- Unauthorized absences;
- Leaves of absence of over 30 days (except military leaves or leaves under the Federal Family and Medical Leave Act);
- Certain absences from which you do not return;
- Periods when you work as a non-regular employee, as a special-agreement person, in a service station, car wash, or car care center operations; or
- When you are covered by a contract that requires the company to contribute to a different benefit program, unless a special authorization credits the service.

**Benefits Administration**

The following sets out the contact numbers based on your status under the ExxonMobil Medical Plan. It is your responsibility to contact Benefits Administration with any required notices and address changes. If your status is not listed, call ExxonMobil Benefits Administration/Health Plan Services for assistance or contact them at hr.medical.dental.questions@exxonmobil.com.

**Phone Numbers**

- Employees, call:

**ExxonMobil Benefits Administration / Health Plan Services**
Monday - Friday 8:00 a.m. to 3:00 p.m. (U.S. Central Time), except certain holidays
713-680-5858 (Houston)
713-680-7070 (international, call collect)
800-262-2363 (toll free outside Houston)

**Address**

**ExxonMobil Benefits Administration/Health Plan Services**
ExxonMobil BA BSC USBA
4300 Dacoma or "BH1"
Houston, TX 77092

- Retirees and Survivors, call:

**ExxonMobil Benefits Service Center**
Monday - Friday 8:00 a.m. to 6:00 p.m. (U.S. Eastern Time), except certain holidays
Toll-Free: 1-800-682-2847
or 800-TDD-TDD4 (833-8334) for hearing impaired

**ExxonMobil Benefits Service Center**

P.O. Box 199540
Dallas, TX 75219-9722

- Former Exxon or ExxonMobil Employees, Exxon or ExxonMobil Retirees, or their Survivors or their Family Members, who elected and are participating through COBRA, call:

**ExxonMobil COBRA Administration**
Monday - Friday 8:00 a.m. to 8:00 p.m. (U.S. Central Time), except certain holidays
Phone: (800) 522-6621
Fax: (770) 619-7160

**ADP Benefit Services**
**ADP National Accounts**
**ExxonMobil COBRA Administration**
P.O. Box 2968
Alpharetta, GA 30023-2968

# Definitions

**Benefits Administration / ExxonMobil Sponsored Sites** — Access to Medical Plan-related information including claim forms for employees, retirees, survivors, and their family members.

- **ExxonMobil Me, the Human Resources Intranet Site** — Can be accessed at work by employees.
- **ExxonMobil Family, the Human Resources Internet Site** — Can be accessed from home by everyone at www.exxonmobilfamily.com.
- **Retiree Online Community Internet Site** — Can be accessed from home by retirees and survivors only at www.emretiree.com.
- **ExxonMobil Benefits Service Center at Xerox Internet Site** — Can be accessed from home by everyone at www.exxonmobil.com/benefits.

**Charges**
The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with Cigna for a different amount.

**Custodial Care**
Care that helps meet personal needs and daily living activities. Such care, even if ordered by a doctor and performed by a licensed medical professional such as a nurse is not covered by the Cigna OAPIN Option.

**Child**
A person under age 26 who is:

- A natural or legally adopted child of a regular employee or retiree;
- A grandchild, niece, nephew, cousin, or other child related by blood or marriage over whom a regular employee, retiree, or the spouse of a regular employee or retiree (separately or together) is the sole court appointed legal guardian or sole managing conservator;
- A child for whom the regular employee or retiree has assumed a legal obligation for support immediately prior to the child's adoption by the regular employee or retiree; or
- A stepchild of a regular employee or retiree.

Child does not include a foster child.

**Durable Medical Equipment**
Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, wheel chairs, and dialysis machines.

**Eligible Employees**
Most U.S. dollar-paid employees of Exxon Mobil Corporation and participating affiliates are eligible. Full-time employees not hired on a temporary basis (also designated "regular employees") are eligible. Extended part time employees, as designated on the employer's books and records, are also eligible.

The following are not eligible to participate in the Medical Plan: leased employees as defined in the Internal Revenue Code, barred employees, or special agreement persons as defined in the Medical Plan document. Generally, special-agreement persons are persons paid by the company on a commission basis, persons working for an unaffiliated company that provides services to the company, and persons working for the company pursuant to a contract that excludes coverage of benefits.

# Definitions

**Eligible Family Members**
Eligible family members are generally your:

- Spouse
- A child who is described in any one of the following paragraphs (1 through 3):
  (1) has not reached the end of the month during which age 26 is attained; or
  (2) is totally and continuously disabled and incapable of self-sustaining employment by reason of mental or physical disability, provided the child:
    (a) meets the Internal Revenue Service's definition of a dependent and
    (b) either
      (i) was or would have been covered as an eligible family member under this Plan immediately prior to the birthday on which the child's eligibility would have otherwise ceased, or
      (ii) was covered as an eligible family member under a predecessor plan which provided for coverage of disability, if the disability occurred prior to the birthday on which the child's eligibility under that plan would have otherwise ceased, the child continued to be considered eligible for coverage because of such disability and the child had not lost eligibility under the predecessor plan; and
    (c) the child is disabled before such birthday and has remained continuously disabled, and
  (3) the child is recognized under a qualified medical child support order as having a right to coverage under this Plan.

A child who was disabled by reason of mental disability but who no longer meets the requirements of paragraphs 2(a) above, ceases to be an eligible family member 300 days following the date on which the applicable requirement is not met.

Please note: An eligible employee or retiree's parents are not eligible to be covered. A child who is not legally present in the United States or a child who resides outside the United States and is not a citizen who doesn't usually reside with the Employee or Retiree is not an Eligible Family Member.

**Emergency Services**
Emergency services are medical, psychiatric, surgical, hospital, and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily injury or serious sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB04 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

**Employer**
The term Employer means Exxon Mobil Corporation and participating affiliated companies, who are self-funding the benefits described in this SPD, on whose behalf Cigna is providing claim administration services.

**Expense Incurred**
An expense is incurred when the service or the supply for which it is incurred is provided.

**Extended Part-time Employee**
An employee who is designated as a non-regular employee but who has been designated as an Extended Part-Time employee under his or her employer's employment policies relating to flexible work arrangements.

# Definitions

**ExxonMobil Medical Plan**
The plan sponsored by Exxon Mobil Corporation, which provides medical benefits for eligible employees, retirees, survivors and their family members and includes as one option the Cigna OAPIN Option.

**Formulary**
Listing of approved drugs and medications approved in accordance with parameters established by the Pharmacy and Therapeutics Committee. This list is subject to periodic review and updates.

**Free-Standing Surgical Facility**
The term Free-Standing Surgical Facility means an institution which meets all of the following requirements:
- It has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- It maintains at least two operating rooms and one recovery room;
- It maintains diagnostic laboratory and x-ray facilities;
- It has equipment for emergency care;
- It has a blood supply;
- It maintains medical records;
- It has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- It is licensed in accordance with the laws of the appropriate legally authorized agency.

**Home Health Aide**
The term Home Health Aide means a person who: (a) provides care of a medical or therapeutic nature; and (b) reports to and is under the direct supervision of a Home Health care Agency.

**Home Health Care Agency**
The term Home Health Care Agency means a Hospital or a non-profit or public home health care agency which:
- Primarily provides skilled nursing service and other therapeutic service under the supervision of a Physician or a Registered Graduate Nurse;
- Is run according to rules established by a group of professional persons;
- Maintains clinical records on all patients;
- Does not primarily provide custodial care or care and treatment of the mentally ill; but only if, in those jurisdictions where licensure by statute exists, that Home Health Care Agency is licensed and run according to the laws that pertain to agencies which provide home health care.

**Home Health Care Plan**
The term Home Health Care Plan means a plan for care and treatment of a person in his home. To qualify, the plan must be established and approved in writing by a Physician who certifies that the person would require confinement in a Hospital or Skilled Nursing Facility if he did not have the care and treatment specified in the plan.

**Hospice Care Program**
The term Hospice Care Program means:
- A coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- A program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- A program for persons who have a Terminal Illness and for the families of those persons.

# Definitions

**Hospice Care Services**
The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program, and is a Medicare approved Hospice Care Program.

**Hospice Facility**
The term Hospice Facility means an institution or part of it which:
- Primarily provides care for Terminally Ill patients;
- Is accredited by the National Hospice Organization;
- Meets standards established by Cigna; and
- Fulfills any licensing requirements of the state or locality in which it operates.

**Hospital**
The term Hospital means:
- An institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- An institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals; or
- An institution which: (a) specializes in treatment of mental illness, alcohol or drug abuse or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution, which is primarily a place for rest, a place for the aged, or a nursing home.

**Injury**
The term Injury means an accidental bodily injury.

**Medicaid**
The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

**Medicare**
The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

**Mental Illness**
The term "mental illness" means any disorder, other than a disorder induced by alcohol or drug abuse, which impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin. In determining benefits payable, charges made for the treatment of any physiological symptoms related to a mental illness will not be considered to be charges made for treatment of a mental illness.

**Necessary Services and Supplies**
The term Necessary Services and Supplies includes any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

# Definitions

**Network**
Providers and facilities that participate in a health maintenance organization available under this Cigna OAPIN Option.

**Nurse**
The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

**Outpatient Mental Illness Services**
Outpatient Mental Illness Services are services of providers who are qualified to treat mental illness when treatment is provided on an outpatient basis, while you or your eligible/covered Family Member is not confined in a Hospital, in an individual, group or structured group therapy program. Covered Services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interferes with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic mental illness conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

**Participating Pharmacy**
The term Participating Pharmacy means a retail pharmacy or mail-order pharmacy with which Cigna has contracted, either directly or indirectly, to provide prescription services to its plan participants.

**Participating Provider**
The term Participating Provider means:
- An institution, facility, agency or healthcare professional which has contracted directly or indirectly with Cigna.

The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers will be provided with this booklet.

**Pharmacy & Therapeutics (P&T) Committee**
A committee of Provider Organization members comprised of Medical providers, Pharmacists, Medical Directors and Pharmacy Directors, which reviews medications for safety, efficacy, cost effectiveness and value. The P & T Committee evaluates medications for addition to or deletion from the Formulary and may also set dispensing limits on medications. Related Services are also reviewed & evaluated.

**Physician**
The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the services are received if he is:

- Operating within the scope of his license; and
- Performing a service for which benefits are provided under this Cigna OAPIN Option when performed by a Physician.

**Prescription Drug**
Prescription Drug means; (a) a drug which has been approved by the Food and Drug Administration for safety and efficacy; or (b) certain drugs approved under the Drug Efficacy Study Implementation review; or (c) drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a prescription order; or (d) injectable insulin.

# Definitions

**Primary Care Physician**
The term Primary Care Physician means a Physician: (a) who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and (b) who has been selected by you, as authorized by the Provider Organization, to provide or arrange for medical care for you or any of your covered Family Members.

**Provider Organization**
The term Provider Organization refers to a network of Participating Providers.

**Psychologist**
The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include: (1) any other licensed counseling practitioner whose services are required to be covered by law in the locality where the services are received if he is: (a) operating within the scope of his license; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist; and (2) any psychotherapist while he is providing care authorized by the Provider Organization if he is: (a) state licensed or nationally certified by his professional discipline; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist.

**Qualified Medical Child Support Order (QMCSO)**
A Qualified Medical Child Support Order (QMCSO) is a court decree under which a court order mandates health coverage for a child. A QMCSO must include, at a minimum:

- Name and address of the Employee covered by the health plan.
- The name and address of each child for whom coverage is mandated.
- A reasonable description for the coverage to be provided.
- The time period of coverage.
- The name of each health plan to which the order applies.

You may obtain, without charge, a copy of the Medical Plan's procedures governing QMCSO determinations by written request to the Administrator-Benefits.

**Retiree**
Generally, a person at least 55 years old who retires as a regular employee with 15 or more years of benefit service and who has not thereafter recommenced employment as a covered employee or a non-regular employee. Retiree status may also be attained by someone who is retired by the company as a regular employee and entitled to long-term disability benefits under the ExxonMobil Disability Plan after 15 or more years of benefit service, regardless of age.

Employees who terminate while non-regular (including extended part-time employees) are not eligible for retiree status regardless of age or service.

**Self-Funded Plan**
A self-funded plan option, under the Medical Plan, is an option set up by ExxonMobil to set aside funds to pay employees' health claims. Because ExxonMobil has hired insurance companies to administer these self-funded options, they may look just like fully-insured plans. For example, the Cigna OAPIN option under the Medical Plan is a self-funded plan.

Cigna is responsible for only administering the plan. (i.e., Cigna is the claims processor for the self-insured plan.) ExxonMobil is responsible for funding the plan to pay health claims. This does not impact the benefits

provided under the Cigna OAPIN Option under the Medical Plan. The U.S. Department of Labor regulates self-funded plans, not the state insurance department.

You may contact the Department of Labor at the address listed in the ERISA section: Assistance with Your Questions.

**Service Area**
The geographic area designated by the Cigna OAPIN Option in which an individual must live in order to be an eligible member. This area is determined by the participant's home address zip code.

**Sickness - For Medical Coverage**
The term Sickness means a physical or mental illness. It also includes pregnancy. Covered Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

**Skilled Nursing Facility**
The term Skilled Nursing Facility means a licensed institution (other than a Hospital) which specializes in:

- Physical rehabilitation on an inpatient basis; or
- Skilled nursing and medical care on an inpatient basis;

but only if that institution (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

**Spouse; Marriage**
All references to marriage shall mean a marriage that is legally recognized under the laws of the state or other jurisdiction in which the marriage takes place, consistent with U.S. federal tax law. All references to a spouse or a married person shall refer to individuals who have such a marriage.

**Terminal Illness**
A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

**Urgent Care**
Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the covered person should not travel due to any medical condition.