ExxonMobil Medical Plan - POS II Options



Summary Plan Description

2014

ExxonMobil

ExxonMobil Medical Plan SPD
POS II "A" and "B" Options
As of January 2014

About The Medical Plan

This summary plan description (SPD) summarizes the **ExxonMobil Medical Plan** (the Plan). It does not contain all plan details. 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, always govern. You may obtain copies of these documents by making a written request to the Administrator-Benefits. Exxon Mobil Corporation reserves the right to change benefits in any way or terminate the Plan at any time.

Both POS II (Point of Service) options are 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 determine the amount of money needed to pay future benefits. These options are governed by federal laws, not by state insurance laws.

If you enroll in any option other than the POS II "A" or "B" option, you may access an additional SPD for that option. If you do not enroll in any option, you are still eligible for Culture of Health programs and certain Partners in Health program benefits described on page 55.

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

Information Sources

When you need information, you may contact:

Claims, Medical POS II Administrator, and Pre-Admission Review — Aetna provides information about claims payment, providers participating in the Medical POS II (Aetna Choice® POS II) network, claims forms, and benefit pre-determinations. In addition, Aetna provides hospital pre-admission review for inpatient medical service, medical case management and pre-certification for skilled nursing care, home health care, private duty nursing, hospice care, and the purchase of durable medical equipment.

Phone Numbers:	Address:
Aetna Member Services 800-255-2386 210-366-2416 (if international, call collect) Monday – Friday 8:00 a.m. to 6:00 p.m. (U.S. Central Time), except certain holidays Automated Voice Response - 24 hours a day, 7 days a week	Aetna P. O. Box 981106 El Paso, TX 79998-1106

Check DocFind® on Aetna's Web site at www.aetna.com/docfind to locate network providers.

Mental Health and Chemical Dependency Pre-Certification and Mental Health PPO — Magellan provides pre-certification, case management, and information about providers participating in the Mental Health PPO network.

Phone Numbers:	Address:
Magellan Behavioral Health 800-442-4123 314-387-4700 (international, call collect) 24 hours a day, 7 days a week	Magellan Behavioral Health 14100 Magellan Plaza Drive Maryland Heights, MO 63043

Check Magellan's Web site at www.magellanhealth.com/member for Life Assistance Resource information such as community resources links, health and wellness tips, and behavioral health Internet sites. Once you have accessed this site:

- Sign in under Member Sign In (new users click on New or unregistered user)
- Enter toll free number: 800-442-4123 (user identification and password not necessary)
- At this point, you may register or continue as unregistered

Prescription Drug Program — Claims processor for outpatient prescription drugs provided through mail order for long-term prescriptions or a local retail pharmacy for short-term prescriptions.

Phone Numbers:	Addresses:
Express Scripts Pharmacy – Mail-order Pharmacy: 800-695-4116 800-497-4641 (international, use appropriate country access code depending on country from which you are calling)	Express Scripts Pharmacy – Mail-order Pharmacy P.O. Box 650322 Dallas, TX 75265-0322
For questions regarding Retail Prescriptions – Express Scripts: 800-695-4116 800-497-4641 (international, use appropriate country access code depending on the country from which you are calling)	Non-network and Coordination of Benefits Retail Prescriptions Claims Processing: Express Scripts P.O. Box 14711 Lexington, KY 40512 64063-2277

Another way to locate retail network pharmacies and order refills is through the Express Scripts web site at www.express-scripts.com.

Benefits Administration — Customer Service Representatives can provide specialized assistance. References to Benefits Administration throughout this SPD pertain to either ExxonMobil Benefits Administration or ExxonMobil Benefits Service Center as listed below. Depending on your status (employee, retiree, or survivor), you should contact the appropriate service center.

Employees can enroll/change benefits on the ExxonMobil Me HR Intranet site through Employee Direct Access (EDA) when a change in status occurs. Enrollment forms are also available through ExxonMobil Benefits Administration for those without access to EDA.

- **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)
  262-314-2752 (fax)

  Address:
  ExxonMobil Benefits Administration
  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
  PO Box 199540
  Dallas, TX 75219-9722

ExxonMobil Sponsored Sites — Access to 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 by everyone at www.exxonmobilfamily.com.
- **Retiree Online Community Internet Site** — Can be accessed by retirees and survivors only at www.emretiree.com.
- **ExxonMobil Benefits Service Center at Xerox Internet Site** — Can be accessed by everyone at www.exxonmobil.com/benefits.

Introduction

The ExxonMobil Medical Plan is made up of POS II options and other options, including both self-insured and fully-insured Plans. This SPD is a summary of your benefits under the POS II options only. It does not contain all the details about the POS II options nor does it contain any information about the other options. If you enroll in any option other than the POS II options, you may access an SPD for that option. Even if you do not enroll in any option, you are still eligible for Culture of Health programs and certain Partners in Health program benefits described on page 55.

The POS II is a network of physicians, hospitals, and other health care providers whose credentials have been reviewed by the network manager and who have agreed to provide their services at negotiated rates. The POS II "A" and "B" are different plan designs utilizing the same network.

The network for medical care covered under the POS II option – referred to as the Medical POS II in this SPD – is offered by Aetna. Aetna Life Insurance Company (Aetna) is the network manager and claims administrator for the Medical POS II.

Aetna does not render medical services or treatments. Neither the Plan nor Aetna is responsible for the health care that is delivered by providers participating in the Medical POS II (Aetna Choice® POS II) and those providers are solely responsible for the health care they deliver. Providers are not the agents or employees of the Plan or Aetna.

The PPO for mental health and chemical dependency care covered under the POS II options – referred to as the Mental Health PPO (MHPPO) in this SPD – is managed by Magellan Behavioral Health.

The POS II options offer you the ability to use physicians and other health care providers that are part of a network. You can generally reduce your out-of-pocket expenses by using network providers.

If you elect the POS II "A" or "B" option and you live outside one of the network areas, you are provided benefits on an out-of-network area basis. However, if you live within the network area and choose to use a non-network provider, specific limitations apply to the benefits you are provided.

These tools help you find specific information quickly and easily:

- **Plan at a Glance**, a user's guide highlighting plan basics.
- **Charts and tables** throughout this SPD provide information, examples and highlights of plan provisions, including **Benefit Summary** charts on pages 81-86
- **References** to places where you can get more information.
- A list of **Key Terms** containing definitions of some words and terms used in this SPD. Terms are underlined and linked for easy identification.

A careful reading of this SPD will help you understand how the POS II option works so you can make the best use of the plan provisions. You may obtain additional information through the sources shown on pages 1-3.

Plan at a Glance

Enrolling
You may enroll yourself and your eligible family members within 60 days of hire or within 60 days of a subsequent change-in-status or at Annual Enrollment. See page 7.

Basic Plan Features
The Medical Plan covers medically necessary and preventive treatment, care and services, that are not otherwise excluded. You can save money and time if you use a provider who participates in the POS II network. When you receive care through the POS II network, the provider files claims and obtains necessary pre-certifications, expenses are within reasonable and customary limits, and the negotiated rates generally lower your out-of-pocket costs. See page 19.

The Prescription Drug Program
The Medical Plan offers you two cost-saving ways to buy prescription drugs – at a local participating network pharmacy for short-term prescriptions and through a mail-order program for long-term prescriptions. See page 26.

Mental Health and Chemical Dependency Care
The Plan provides for mental health and chemical dependency care through Magellan's nationwide mental health PPO. All non-network inpatient care must be pre-certified. See page 33.

Covered and Excluded Expenses
The Medical Plan provides benefits for many, but not all, treatment, care and services. See **Covered Expenses** on page 38 and **Exclusions** on page 43.

Payments
You and the Medical Plan share costs for covered treatment and services. You pay a fixed co-payment for covered items such as a POS II network doctor's office visit and most related lab work. For other types of care, you must first satisfy a deductible before the Medical Plan begins paying. If you meet your annual out-of-pocket limit, the Medical Plan pays 100% of most covered costs for the rest of that calendar year. See page 45.

Claims
POS II network providers file claims for you. You are responsible for ensuring that claims for non-network care are filed. See page 53.

Culture of Health and Partners in Health Programs
Tools and resources are available to you and your family members to help you better manage your health and health care. The health portal (Internet site), health assessment, 24-hour nurse line, and lifestyle coaching are available to everyone, including retirees if enrolled in an EMMP option. Participants who are enrolled in the POS II option, Aetna Select or Cigna Open Access Plus – In Network options and who meet certain qualifications have access to several programs — Health Advocate, Disease Management and Centers of Excellence Programs — to help access the best available treatment. See page 55.

Consolidated Omnibus Budget Reconciliation Act 1985 (COBRA)
You and your family members who lose eligibility may continue medical coverage for a limited time under certain circumstances. See page 58.

Administrative and ERISA Information
This Plan is subject to rules of the federal government, including the Employee Retirement Income Security Act of 1974, as amended (ERISA), not state insurance laws. See page 63.

Key Terms
This is an alphabetized list of words and phrases, with their definitions, used in this SPD. These words are underlined and linked throughout the SPD for easy identification. See page 70.

Benefit Summaries
Brief summaries of benefits for the POS II "A" and "B" options. See pages 81-86.

Eligibility and Enrollment

Q. What are the Medical Plan's eligibility requirements?

A. Most U.S. dollar payroll regular employees of Exxon Mobil Corporation and participating affiliates are eligible for this Plan.

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 Part A or B.
- You are a survivor, which means an eligible family member of a deceased regular or extended part-time employee or retiree.
- You are an expatriate employee required to participate in the Medical Plan.

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 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 18.

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 enrolled in the ExxonMobil Medicare Supplement Plan, as long as that spouse or child is not eligible for Medicare.

Refer to **Key Terms** for definitions of eligible family members, child, suspended retiree, spouse, and Qualified Medical Child Support Order.

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 family members of a deceased suspended retiree will be eligible for coverage under this Plan 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 dependent 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 leaves of absence.

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 on the next page.

	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

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.

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 employee (or retiree), 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.

How to Enroll

As a newly hired employee, if you enroll 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. You must enroll everyone in the same 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 **Changing Your Coverage** on page 12).

As a current employee, if you are not covered by a medical plan to which ExxonMobil contributes and would like to enroll in the Medical Plan, 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.

You can enroll eligible family members only if you are enrolled in an EMMP option or in the ExxonMobil Medicare Supplement Plan. 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.

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 requested 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 EMMP 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 EMMP 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 EMMP OPTION, SUCH AS FROM AN AETNA SELECT OR CIGNA 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.

Under the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 you may change your EMMP 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 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.

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 EMMP 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. If you are enrolled on an after-tax basis, you may add an eligible family member to your existing option effective the first of the following month following receipt of your written election by Benefits Administration.

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 will have to 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.

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

Changes During the Year - Medical/Dental/Vision (Health Plans)

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.
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	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.

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 an after-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 58 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 stepchildren 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.

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 your 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.

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 Ex xonMobil Medicare Supplement Plan.

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 58 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 58 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.

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 not to 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 Plan (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 Plan);
  - 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;
  - An expatriate employee's assignment to the United States ends;

  OR
- The date:
  - You die;
  - The Medical Plan ends;
  - Your employer discontinues participation in the 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 children who do not meet the eligibility requirements.

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.

Basic Plan Features

Q. What are the basic features of the POS II options?

A. The basic features of the POS II options are:

- The Plan generally covers only medically necessary care and services.
- Inpatient hospital stays must be pre-certified for maximum benefit allowed by the Plan.
- The Medical POS II network of participating providers offers you savings in both time and money.
- Preventive care provisions help you stay healthy.
- The Plan offers you the opportunity to have your benefits determined before a procedure is performed.

Both POS II options include the features listed below.

Medically Necessary

Expenses are covered under these options only if they are medically necessary. Care is medically necessary if it is a therapeutic procedure, service or supply used in the medical treatment of an injury, disease, or pregnancy, which is generally recognized by the United States medical community as appropriate. Claims are reviewed as submitted, and some or all of any claim or series of services could be denied as not being medically necessary. It also means that experimental or investigational procedures, drugs, devices or biological products not proven by long-term clinical studies are generally not covered. See page 43 for limited exceptions.

When determining medical necessity, the Administrator-Benefits may consider the Clinical Policy Bulletins (CPBs) published by Aetna, the claims administrator. CPBs are based on established, nationally accepted governmental and/or professional society recommendations, as well as other recognized sources. These CPBs may be found on the Aetna Web site at www.aetna.com or the Aetna Navigator™ Web site at www.aetnanavigator.com.

Pre-Certification/Pre-Determination

For Any Hospital Stays:
Generally, a hospital stay must be pre-certified before you are admitted. See the **Information Sources** section at the front of this SPD for the telephone numbers. However, there are other services that require pre-certification as listed on the next page.

If you do not pre-certify a non-POS II provider or non-mental health PPO hospital stay, you will be responsible for the first $500 of eligible expenses. In addition, if a hospitalization does not meet the requirements for benefit coverage, the Plan will not reimburse you for room and board charges related to the stay and/or for any services not covered or medically necessary.

Pre-certification should be obtained prior to any hospital inpatient stay (including mental health and chemical dependency) to give notice of inpatient admission and the proposed care. The following outlines services that need to be pre-certified. If you are unsure if the service you are seeking requires pre-certification, call Aetna Member Services.

For Non-Emergency Medical Care:

- Hospitalization
  - If you are using a POS II network provider, or a mental health PPO network provider, your provider will handle the pre-certification process for you.
  - Before you are admitted to a hospital that does not participate in the POS II or mental health PPO network, you must call Aetna for a medical pre-admission review or Magellan for a mental health confinement. This is required for most inpatient admissions, including extended-care facilities.
  - You are not required to call to pre-certify:
    - Hospitalization outside the United States, for both medical and mental health or substance abuse; or
    - Outpatient surgery, even if performed in a hospital.
- Durable medical equipment
  - In order to maximize your benefits for the purchase or repair of durable medical equipment, call Aetna Member Services to locate a network provider or to obtain a pre-determination (recommended for any durable medical equipment). You should also verify with Aetna Member Services whether a pre-certification is required for the purchase or repair of durable medical equipment. For example, a power wheelchair requires a pre-certification.
- Hospice care.
- Extended care facility.
- Skilled nursing care.
- Home health care.
- Private duty nursing.
- Complex imaging including CT scans, coronary CT angiography, MRI/MRA, nuclear cardiology, PET scans, and echo stress tests.
- Defibrillators and pacemakers not a result of emergency treatment.
- Heart catheterizations.
- Facility-based sleep studies.
- Cardiac rhythm implantable devices.
- Comprehensive infertility services, including some treatments and services known as Advanced Reproductive Technologies (ART), including in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) and frozen embryo transfer (FET) only if obtained at an Aetna-designated Institute of Excellence.

Benefit Pre-Determinations
You can call Aetna Member Services to determine in advance whether a particular treatment or service is covered under your POS II option and whether the proposed cost is within reasonable and customary limits for out of network providers. See the **Information Sources** section at the front of this SPD.

In most cases, you may receive an answer over the phone. However, an estimate of the benefits payable for covered services is not a guarantee of benefit eligible for payment, nor the amount. In other cases, information from your provider may be needed. You or your doctor can also request a pre-determination of benefits, in writing, before the service is performed.

This pre-determination may require review by one or more doctors. Be sure to allow time for this review between the pre-determination request and the proposed date of the service. By obtaining the written response, you will have more detailed information about the level of reimbursement.

When you call for a benefit pre-determination, be ready to provide the following information:

- Primary participant's name and member ID, which can be found on your Aetna ID card;
- Patient's name;
- Complete description of medical services or surgical procedures. If possible, include the diagnosis code(s) and the five-digit Current Procedural Terminology (CPT) codes, which you can get from the provider;
- Provider's ZIP code; and
- Provider's proposed fee for each service.

For Emergency Inpatient Admissions:
Certification must be made within 48 hours following an emergency inpatient admission. If the admission is on a weekend or holiday, notification must be made within 72 hours.

- If you are using a POS II network provider, your provider will obtain certification for you.
- You or someone acting on your behalf must call to certify care if you are in a non-network or out-of-network area hospital.

For Mental Health or Chemical Dependency Care:
You should call Magellan Behavioral Health for pre-certification of any mental health or chemical dependency care. This applies whether you are inside or outside the United States.

The Aetna POS II network is not used for mental health or chemical dependency care. Contact Magellan Behavioral Health for network information and pre-certification of mental health or chemical dependency care. See the **Information Sources** section on page 1.

If you require mental health or chemical dependency care in conjunction with a medical emergency, you must notify Magellan within the appropriate time periods described on page 34**.**

For Certain Prescription Drugs:
You must call Express Scripts for pre-certification of certain prescription drugs. This applies whether you are inside or outside the United States.

In the therapeutic chapters listed below, there will be targeted drugs determined by Express Scripts which will not be covered unless pre-certified by Express Scripts. Non-targeted drugs will be covered without such authorization, and will continue to be dispensed with no further action by either a participant or the prescribing physician. These classes are proton pump inhibitors, sleep agents, depression, osteoporosis, respiratory, cardiovascular, triptans, glaucoma, diabetes, respiratory allergy/asthma, anti-inflammatory and rheumatoid arthritis and growth hormone. Additional prior authorization rules apply to certain therapeutic chapters of drugs; miscellaneous immunological agents, central nervous system/miscellaneous neurological therapy, biotechnology/adjunctive cancer therapy, central nervous system/headache therapy, central nervous system/analgesics, neurology/miscellaneous psychotherapeutic agents, miscellaneous pulmonary agents, anabolic steroids, high cost antibiotics, antiemetics, antivirals, narcotics, acne dermatologicals, and topical pain. Certain drugs within each chapter as determined by Express Scripts will only be covered to the extent they are authorized by Express Scripts. **If you have a question regarding a drug in any of these therapeutic chapters, contact Express Scripts to determine whether your drug is covered without pre-certification.**

About Pregnancy

Federal law mandates that benefit programs such as the Medical Plan cover eligible participants for a minimum length of stay for delivery and newborn hospitalizations. Those minimums are 48 hours following a vaginal delivery and 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Medical POS II Network

The network includes a group of physicians, hospitals, and other providers who have met standards for licensing, academic background and service. If you use network providers, the Plan pays a larger portion of the covered expenses. Network providers have agreed to negotiated charges which may save you and the plan money. Other advantages to using Medical POS II network providers for medical care are:

- Most office visits, diagnostic laboratory and X-ray work are reimbursed at 100%, unless related to surgery or emergency.
- Emergency room physician expenses, in-patient hospital, outpatient surgery or complex surgery are subject to deductible and coinsurance.
- Other expenses such as home health care, durable medical equipment or complex imaging are reimbursed at the network reimbursement level (either 80% for the POS II "B" or 75% for the POS II "A") of a negotiated rate after you meet the annual deductible.
- Your annual out-of-pocket maximum is significantly lower.
- Medical POS II network providers file claims and handle the hospital pre-admission review process for you.
- All negotiated charges are within reasonable and customary limits (see definition on page 46).

Anyone in the POS II "A" or "B" option may receive network benefits by using Aetna Choice®POS II network providers.

Network Locations
Medical POS II networks are located throughout the United States. As explained on page 4, the Medical POS II is part of the Aetna Choice® POS II network.

You are a network participant if you live in a Medical POS II area. These are some of the Medical POS II areas:

- Billings, Montana
- Beaumont, Texas
- Baton Rouge, Louisiana
- Dallas, Texas
- Fairfax, Virginia
- Houston, Texas
- New Orleans, Louisiana
- Torrance, California

If you or an eligible family member resides in a network area, you can use Aetna's Internet DocFind® (www.aetna.com/docfind) to locate providers in the area. ExxonMobil Me, the HR Intranet site, has a ZIP code search tool that identifies whether your home address ZIP code is located in an Aetna network area or in an out-of-network area.

Benefits Based on the Network Status of the Provider
Generally, you will receive network benefits only if the provider is in the Medical POS II network. This applies whether or not the care is received in a network area or in an out-of-network area.

To Find an Aetna Choice® POS II Provider:

- Check DocFind® (www.aetna.com/docfind) on Aetna's Web site for the most up-to-date list of Choice® POS II providers. The site is updated six times a week, excluding holidays, Sundays or during interruptions due to system maintenance, upgrades or unplanned outages. Before your appointment, confirm with Aetna Member Services, DocFind®, or the doctor's office whether the doctor participates in the network, because network participation may change.
- Call Aetna Member Services for help with locating a POS II network provider.

Co-Payment for Office Visits/Lab Work when provided by a primary care physician; higher co-payment when provided by a specialist.
When you use Medical POS II network providers for office visits, you are not subject to the annual deductible. You pay a co-payment for each office visit, including most related lab work and radiology performed by a POS II network provider.

A co-payment does not apply to more extensive tests, including complex imaging (i.e., CT scans, MRI, MRA, PET/SPECT), radiopharmaceutical stress tests, angiography myelography, MUGA scans and sleep studies, which are subject to the deductible and co-insurance.

If an injection (other than an injection into a vein or artery) is received in a network doctor's office without an office visit, the co-payment will be the actual cost of the injection or the office visit co-payment, whichever is less. For infusion therapy and chemotherapy, a fixed co-payment only applies to the office visit. All other related services are paid at coinsurance. Allergy serum dispensed by a network doctor for at home use is reimbursed at coinsurance after the deductible.

These co-payments do not apply to your annual deductible but do apply to your annual out-of-pocket limit. See the explanation beginning on page 45 for more information about deductibles and co-payments.

Is Your Doctor a Network Provider?
Call your doctor's office to confirm his or her participation in the Aetna Choice® POS II network. If your doctor is not participating, ask him or her to consider applying to participate. Your doctor can obtain information about becoming a network participant from Aetna's Web site (www.aetna.com/healthcare-professionals/index.html) or by calling Aetna Credentialing Customer Service at 1-800-353-1232.

If an Aetna Choice POS II network provider is not available within your access area, you may contact Aetna Member Services for information regarding the Plan's alternative network deficiency benefit. The alternate benefit is designed to address any network deficiency situations.

Show Your ID Card
When you visit a physician or other health care provider, present your Medical Plan identification card. This helps the provider confirm your eligibility and understand your benefits coverage.

If you show your ID card to a network provider, the office staff should only ask you for your co-payment and any deductible amounts, not for full payment.

If You Live in a Medical POS II Network Area and Do Not Use Medical POS II Network Providers
When you use non-network providers:

- Your out-of-pocket costs will generally be higher. The Plan's reimbursement level is 60% for the POS II "B" and 55% for the POS II "A" of reasonable and customary charges, after you satisfy the deductible.
- You must call Aetna to initiate the medical pre-admission review process for inpatient treatment.
- If your provider's charges are above reasonable and customary limits, you are responsible for paying any amounts above reasonable and customary limits.
- You are responsible for submitting claims.

Emergency Care
Go to the nearest hospital for treatment. Benefits for emergency care (as a result of emergency outpatient treatment or an emergency admission to a hospital following emergency outpatient treatment received at the same hospital) are paid at the network reimbursement level for both network and non-network providers. However, the network reimbursement level for emergency care by non-network providers is only payable until the patient is determined able to be safely transferred to a network facility.

Reimbursement for emergency services from non-network providers are limited to reasonable and customary amounts, including services for radiology, pathology, anesthesiology, ambulance or emergency room physician services. In most instances, the provider will accept this reimbursement; however in the event you are billed for any balance, you may submit the balance to Aetna for additional processing. If you do so and you are enrolled in the automatic rollover process to the Health Care Flexible Spending Account (HCFSA), an overpayment from the HCFSA may result, and you should contact Aetna to discuss options to return the overpaid HCFSA funds back into the account.

When you go to the emergency room, you are subject to a deductible. If you are admitted as an inpatient to the hospital following emergency outpatient hospital treatment, the deductible amount will apply to your separate inpatient hospital deductible. See pages 81-86.

Urgent Care
Your physician may direct you to an Urgent Care Center as an alternative to a hospital emergency room when he or she feels it is appropriate to do so. If you or a family member receive care at a network urgent care center, you will pay the applicable co-pay, equal to the specialist physician co-pay under your plan option, and the plan pays the remaining charges. If you live in a network area, and you use a non-network urgent care center, you will be reimbursed at the non-network level (either 60% for the POS II "B" or 55% for the POS II "A"), after the plan year deductible has been satisfied. If you live in an out of network area, you will be reimbursed at the out of network area level (either 80% for the POS II "B" or 75% for the POS II "A") after you have met your deductible.

Care While Traveling
For non-emergency care, call Aetna Member Services to identify a nearby POS II network provider or check DocFind® on Aetna 's Web site (www.aetna.com/docfind).

If You Live Outside a Medical POS II Network Area
If you live outside a Medical POS II network area, you are considered to be in an out-of-network area and you will be reimbursed at 80% for the POS II "B" and 75% for the POS II "A" of reasonable and customary charges when you use a non-network provider for services other than those listed under Emergency Care. In addition, you must satisfy the deductible for all covered services other than preventive care. **You are responsible for initiating the medical pre-admission review process for inpatient treatment unless you use a network provider.**

Even though you may not live in a Medical POS II network area, you may live in or near locations where there are Medical POS II providers. If you receive care from an Aetna Choice® POS II network provider — even while traveling — you will receive network reimbursement and network co-payments will apply.

If a Covered Family Member Lives Away from Home
If you live in a Medical POS II network area and you have a covered family member who lives away from home (for instance, you have a child away at school), your family member's ZIP code determines the level of benefits the Plan pays.

Call Aetna Member Services with your family member's ZIP code to find out if Aetna has a Choice® POS II network in the area. If a network is there, you can contact Aetna Member Services or use the Internet DocFind to identify providers in the area. Here is how benefits are determined:

- If your family member receives care from a network provider, benefits will be paid at the network level.
- If your family member lives in a Medical POS II network area but uses non-network providers, benefits are paid at the non-network level.
- If your family member lives in an area where the Medical POS II network is not available and receives care from a non-network provider, benefits are paid at the out-of-network area level — regardless of whether you live in a network or non-network area — if you have notified Aetna of your family member's address.

Upon request, Aetna Member Services will provide an identification card for your family member.

Preventive Care
Certain preventive care services will be covered at 100%. If you use a non-network provider or live in a location where there is not a Medical POS II network, reasonable and customary charges for covered preventive care services will continue to apply. Preventive care services covered at 100% include the following:

- Immunizations
- Prostate-Specific Antigen Test (PSA)
- Digital Rectal Examination (DRE)
- Routine Adult Physical
- Routine Mammography
- Routine GYN Exam
- Routine Well Baby Exam (includes hearing exam if under age 7)
- Routine Well Child Exam (includes hearing exam if under age 7)
- Colorectal Cancer Screening
    - Double Barium Enema
    - Fecal Occult
    - Sigmoidoscopies
    - Colonoscopy

To receive preventive care benefits, the doctor's bill must indicate that the service is preventive in nature. If you are found to have a condition requiring additional treatment, the additional covered services will be paid after you meet any remaining annual deductible.

The Prescription Drug Program

Q. Does the Plan cover prescription drugs?

A. Yes. The Plan contains a prescription drug program that offers you two cost-saving ways to buy outpatient prescription drugs. This program is the same for the POS II "A" and "B" options. You may buy your prescriptions through:

- A network of local participating retail pharmacies for short-term prescriptions.
- Express Scripts Pharmacy, the mail-order pharmacy for long-term or maintenance prescriptions.
- Express Scripts Specialty Pharmacy.

Short-Term Prescriptions

A short-term prescription is written for a drug taken for a limited period of time, such as an antibiotic for a specific illness. The Plan generally provides benefits for up to a 34-day supply. See page 31 for special provisions.

You have the choice of filling your prescriptions at:

- A local participating retail pharmacy (part of Express Scripts' extensive network of pharmacies), where you will pay your share of the discounted cost, and there are no claims to file.
- A non-participating retail pharmacy of your choice, where you will pay the full price and file a claim for partial reimbursement of the cost.

The Participating Retail Network Pharmacy
You may call Express Scripts or check the Express Scripts Web site (www.express-scripts.com) to locate a participating retail pharmacy near you.
When you fill a prescription, you must identify yourself as a member of Express Scripts' retail pharmacy program to maximize your savings.

Percentage Co-Payment
For prescription drugs purchased at a participating retail pharmacy, you pay a percentage of the discounted cost of the drugs:

Type of Drug	Retail Pharmacy Percentage Co-Payment
Generic drugs	30%
Preferred brand name drugs	30%
Non-preferred brand name drugs	50%

Examples:

Generic drug purchased at a retail network pharmacy — discounted cost of medication is $20

You pay a 30% co-payment ($20 x .30)	=	$6

Preferred brand name drug purchased at a retail network pharmacy (if no generic is available) — cost of medication is $40

You pay a 30% co-payment ($40 x .30)	=	$12

Non-preferred brand name drug purchased at a retail network pharmacy — cost of medication is $60

You pay a 50% co-payment ($60 x .50)	=	$30

Retail Refill Limitation
For the third and subsequent refills of a long-term or maintenance drug, which is a drug you take for an extended period of time, such as for ongoing treatment of diabetes, arthritis, a heart condition or blood pressure, you will pay an additional 25% co-payment. The additional 25% co-payment does not apply to your annual prescription drug out-of-pocket maximum.

How to Obtain Your Prescription or a Refill

- Refills can be obtained if prescribed and needed. You must have used at least 75% of the previous prescription, based on the dosage prescribed, before you can refill and receive plan benefits.
- To receive the discounted price, present your prescription and either your prescription drug identification card or the primary participant's identification number at a participating network retail pharmacy. See the definition for primary participant on page 78.
- The pharmacist enters the prescription and the primary participant's Social Security number or ID number into the pharmacy's computer system to confirm:
    - That the participant or family member is covered.
    - That it is a covered prescription.
    - The prescription's cost share.
- No claim filing is necessary.

The term **Primary Participant** refers to the participant whose identification number is used. The primary participant is the employee, retiree, survivor, or individual who elected COBRA coverage. Covered family members use the primary participant's identification number to access all medical benefits. Be sure to give identification cards or the primary participant's identification number to your spouse and any covered family members who may live away from home.

Note: Family members who elect COBRA coverage must use their identification number after the date they enroll as a COBRA participant.

Using a Non-Participating Pharmacy or Not Showing Your Express Scripts or Medco ID Card
You are not eligible for a discounted price if you have your prescription filled at a non-participating retail pharmacy or fail to show your prescription drug ID card at a participating network retail pharmacy. You may print out a temporary ID card if you have registered for access to your personal account on the Express Scripts website at www.express-scripts.com.

- You pay the full price of the prescription at the time of purchase.
- You must submit a completed Direct Reimbursement Claim Form to Express Scripts within two years following purchase. You may obtain a claim form by accessing the ExxonMobil Family Internet site or by contacting Express Scripts at the number shown in the front of this SPD.

- You will be responsible for:
  - 100% of the difference between the non-discounted and the discounted cost of the prescription (the ineligible cost)
    PLUS
  - Your percentage co-payment portion of the discounted cost

Long-Term Prescriptions

A long-term or maintenance drug is one you take for an extended period of time, such as for ongoing treatment of diabetes, arthritis, a heart condition or blood pressure. The Plan generally provides benefits for up to a 90-day supply. See page 31 for **Special Provisions**.

How to Get Started with Express Scripts Pharmacy
If you need maintenance medication immediately, ask your doctor for two prescriptions — one for an immediate supply to be filled at a local retail pharmacy and a second for an extended supply to be ordered through the mail-order pharmacy.

Mail-Order Pharmacy Prescriptions
With Express Scripts Pharmacy, the mail-order pharmacy, you save money and have the convenience of home delivery. Ask the doctor to write a prescription for up to a 90-day supply with appropriate refills. Enclose your original prescription(s) and payment of your percentage co-payment in an envelope. If you are paying by check or money order, you may obtain a calculation of your percentage co-payment from the Express Scripts Web site or by calling Express Scripts directly. If you are paying by credit card, Express Scripts will deduct the appropriate percentage co-payment and you will receive notification of the deduction with your medication. For each prescription filled, you pay:

Type of Drug	Express Scripts Pharmacy Percentage Co-Payment
Generic drugs	25%
Preferred brand name drugs	25%
Non-preferred brand name drugs	45%

Your prescription will be delivered to the address on your order form within 14 working days. By law, prescriptions may not be sent outside the U.S.

You may order refills by calling Express Scripts or sending in the refill label provided with your previous order. You may also order refills through Express Scripts' web site. You should order a refill about three weeks before your current supply will be exhausted, but remember that you must have used at least 75% of the previous prescription based on the prescribed dosage.

Whether you fill prescriptions through Express Scripts Pharmacy or at a local retail pharmacy:
- Your payments and co-payments under the outpatient prescription drug benefits do not apply toward your deductible for other benefits under the Plan.
- Your prescription drug payments and co-payments do not apply toward your annual medical out-of-pocket limit.
- Your prescription drugs annual out-of-pocket maximum is $2,500 for each individual in your family, or $5,000 for your entire family. Additionally, there is a per prescription out-of-pocket maximum as shown in the table below.
- The additional cost for purchasing brand-name prescription drugs when a generic is available, in addition to the additional coinsurance charged for purchasing third and subsequent refills of maintenance medication obtained at retail pharmacies, will not count toward your annual out-of-pocket maximum.

Type of Drug	Retail Per Prescription Out-of- Pocket Maximum	Mail Per Prescription Out-of-Pocket Maximum
Generic	$50	$100
Preferred Brand Name Drug	$115	$200
Non-Preferred Brand Name Drug	$170	$300

Comparing Retail Pharmacy with Express Scripts Pharmacy

This example shows how you can save money by purchasing long-term medication through Express Scripts Pharmacy, the mail-order pharmacy.

At a Participating Retail Pharmacy		Through Express Scripts Pharmacy	
$108.00	Cost of formulary preferred brand name drug (30-day supply)	$324.00	Cost of formulary preferred brand name drug (90-day supply)
x 30%	Percentage co-payment	x 25%	Percentage co-payment
$32.40	Your co-payment	**$81.00**	Your co-payment
You pay **$32.40**, or **$97.20 for 3 purchases**.		You pay **$81.00**.	

By purchasing a 90-day supply of this prescription through mail order, you would save $16.20. That is $64.80 a year for one prescription. Note: This example does not include in the calculation the additional 25% co-payment for the third and any subsequent refills from a participating retail pharmacy. Actual savings may be greater.

Covered Prescriptions

The prescription drug program covers drugs, medicines, and supplies that are:

- Obtainable only with a physician's prescription or are specifically covered expenses (see **Covered Expenses** on page 38).
- Approved by the U.S. Food and Drug Administration for the specific diagnosis.
- Medically necessary.
- Not experimental or investigational.

If You Participate in the Pre-tax Spending Plan Health Care Flexible Spending Account
Do not file a claim for pre-tax benefits for your prescription drug out-of-pocket expenses. Express Scripts will notify Aetna of your prescription purchase, and Aetna will process the claims for any pre-tax reimbursement due you.

Generic Drugs
The program encourages consideration of generic alternatives, which are less expensive to you and the Plan. About half of all brand name medications have a generic equivalent available. By law, the brand name and generic medications must meet the same standards for safety, purity, strength and effectiveness. The pharmacist will dispense only generics that receive FDA approval and only if authorized by your doctor.

Note: If both generic and brand name drugs are available to treat your condition, your percentage co-payment amount will depend on which medication you select.

If you purchase the brand name drug, you are responsible for paying the generic drug percentage co-payment PLUS the difference in cost between the generic drug and the brand name drug up to the brand per prescription maximum. This difference in cost will not count toward your annual prescription drug out-of-pocket maximum.

Here is an example of how you can save by choosing a generic drug at a retail pharmacy when a brand-name drug is available on the Plan's formulary list of medications.

Cost Difference Between Brand and Generic	Percentage Co-Payment
$85.00 Cost of brand name drug (30-day supply) $50.00 Cost of generic drug (30-day supply) **$35.00** Difference in cost	If you purchase the generic drug: $50.00 Cost of generic drug (30-day supply) x 30% Percentage co-payment **$15.00** Your percentage co-payment if you purchase the generic If you purchase the **brand name** drug: Your co-payment will be $15.00 + $35.00 (difference in cost) = **$50.00** The additional $35 does not count toward your annual prescription drug out-of-pocket maximum.

Available Alternatives
Sometimes, a generic drug or a less expensive brand name drug which provides the same therapeutic effect at a lower cost to you may be available. If so, the network system will inform the pharmacist that a less expensive alternative medication is available to fill your prescription. A pharmacist from the network or Express Scripts Pharmacy may contact your doctor to discuss the generic or less expensive brand name alternative. If the doctor authorizes a substitution, the pharmacist will dispense it based solely on your doctor's agreement. If Express Scripts Pharmacy fills a prescription with a generic or an alternative brand name drug, your order will include an explanation of the doctor's change and a credit for any excess percentage co-payment.

The Network Formulary Program
A formulary is a list of commonly prescribed medications within particular therapeutic categories. The drugs on the list have been selected based on their effectiveness and cost.

To be included in the formulary list, a drug must meet rigorous standards of approval by the Express Scripts Pharmacy and Therapeutic Committee — a group of nationally recognized medical professionals.

It is always up to your doctor to decide which medications to prescribe. You may receive a copy of the network's formulary list to share with your doctor by contacting Express Scripts.

Drug Monitoring Service
All prescriptions, both mail order and retail, are screened by the network's computerized drug monitoring service. This service analyzes all of your prescriptions in the system for potential problems such as adverse drug interactions, drug duplications, and unusually high or low dosages. This monitoring service may also detect if a refill is requested too soon. If a potential problem is detected, the drug monitoring service transmits a message to the pharmacist.

The pharmacist will contact your doctor about the potential problem or otherwise resolve the issue before dispensing the prescription.

Of course, your doctor makes the final decision about any change in your prescription or course of treatment.

Special Provisions

In most cases, the pharmacist will fill the prescription according to the doctor's written orders. However, there are some limitations:

- If the prescription is written for an amount that is greater than the Plan covers, the pharmacist will fill the prescription up to the Plan limit. You have the option of buying the additional amount at that time if purchasing at a retail pharmacy, but there is no Plan benefit.
- If the medicine is a controlled substance or if there is a manufacturer's or prescription benefit manager's directive, a smaller amount may be provided.
- You must have used at least 75% of the previous prescription, based on the dosage prescribed, before you can obtain a refill and receive Plan benefits.

Excluded Prescriptions
Prescription medications including injections, billed by and provided in a hospital or a doctor's office, are **not** covered under the prescription drug program but may be covered medical expenses processed by Aetna. Medications billed to you by a pharmacy vendor are processed as part of the prescription drug program administered by Express Scripts. However, the shingles vaccine, Zostavax, when medically necessary, may be covered either under the medical plan if billed by and provided in a hospital or a doctor's office or under the prescription drug program if obtained from a pharmacy and administered by a physician.

Preferred Drug Step Therapy Rules
Preferred drug step therapy rules are used for certain therapeutic chapters of drugs, to encourage the use of effective, lower-cost drugs by excluding some targeted medications from coverage. In the therapeutic chapters proton pump inhibitors, sleep agents, depression, osteoporosis, respiratory, cardiovascular, triptans, glaucoma, diabetes, respiratory allergy/asthma, anti-inflammatory and rheumatoid arthritis, and growth hormone, there will be targeted drugs determined by Express Scripts which will not be covered unless pre-certified by Express Scripts. Non-targeted drugs will be covered without such authorization and will continue to be dispensed with no further action by either you or the prescribing physician. Oral oncology medications will also be limited to ensure appropriate use. **If you have a question regarding a drug in any of these therapeutic chapters, contact Express Scripts to determine whether your drug is covered. You will be notified directly by Express Scripts if you are affected by these rules.**

Prior Authorization Rules
New prior authorization rules apply to certain therapeutic chapters of drugs; these classes are miscellaneous immunological agents, central nervous system/miscellaneous neurological therapy, biotechnology/adjunctive cancer therapy, central nervous system/headache therapy, central nervous system/analgesics, neurology/miscellaneous psychotherapeutic agents, and miscellaneous pulmonary agents. In addition, anabolic steroids, high cost antibiotics, anti-emetics, antivirals, narcotics, acne dermatologicals and topical pain medications may trigger a prior authorization. Certain drugs within each chapter as determined by Express Scripts will only be covered to the extent they are authorized by Express Scripts. **If you have a question regarding coverage for a drug in any of these therapeutic chapters, contact Express Scripts. You will be notified directly by Express Scripts if you are affected by these rules.**

Medical Management
Self- Administered and Rare Disease specialty drugs are only available through the Express Scripts Pharmacy. You will be notified directly by Express Scripts if you are affected by these rules.

When a Prescription Drug Becomes Available Over the Counter
When a prescription medication becomes available over the counter so that it can be purchased without a prescription (at the same strength and for the same use), it will no longer be covered under the Prescription Drug Program. In addition, other drugs in the same therapeutic class may be excluded from the program, but this determination will be made on a case-by-case basis, based on clinical data available at that time.

Coordinating Benefits for Prescriptions
The Medical Plan coordinates benefits with any other group medical plan under which you or your family members are covered, which is described in more detail on pages 51-52. This information is provided to the prescription drug network.

When a pharmacist reviews your or your family member's eligibility information in the network system, a code will indicate if your or your family member has other coverage that should pay benefits first. In these cases, you must first pay according to the primary plan provisions (i.e. you cannot purchase prescriptions using the Express Scripts or Medco card or through the Express Scripts Pharmacy). After the primary plan has paid, you may file a claim for reimbursement of any remaining amount; the procedure is the same as when a non-participating pharmacy is used. The Plan will pay the lesser of what would have been paid under this Plan or the amount not paid by the primary plan.

Mental Health and Chemical Dependency Care

Q. Do the POS II "A" and "B" options cover mental health and chemical dependency treatment?

A. The Plan provides for mental health and chemical dependency care through a nationwide mental health PPO (MHPPO) administered by Magellan Behavioral Health. The Aetna network is not used for mental health or chemical dependency care. Magellan Behavioral Health provides pre-certification of both inpatient and outpatient treatment, provider referral, ongoing consultation and review, and case management for mental health and chemical dependency treatment.

The POS II options include a number of provisions specific to mental health and chemical dependency treatment.

Pre-Certification

All outpatient and inpatient mental health and chemical dependency care should be pre-certified by Magellan Behavioral Health. Pre-certification for inpatient care may be required. The health care provider is responsible for obtaining pre-certification for inpatient network care. The participant is responsible for obtaining pre-certification for services for inpatient non-network and out-of-network care; if pre-certification is not obtained, a $500 penalty will be assessed for failure to pre-certify inpatient non-network and out-of-network care.

Pre-certification is required even if the Plan is secondary to other medical coverage. Whenever treatment for mental health or chemical dependency is needed, call Magellan Behavioral Health. The telephone numbers are shown in the **Information Sources** section at the front of this SPD.

When you talk to the specially trained Magellan counselor, he or she will discuss your needs with you. For employees and their family members, this service is available through ExxonMobil's Employee Health Advisory Program (EHAP). EHAP is not available to retirees and their covered family members who have not elected COBRA. In some cases, up to eight sessions with a counselor are available at no cost to you. However, if more intense or specialized services are needed than are available through EHAP, you may be referred to a network provider immediately upon evaluation. If more treatment or specialized services not offered by EHAP are needed after you have attended some EHAP sessions, the counselor will offer you a choice of network providers in the appropriate specialty area.

Special Rules

Emergency Treatment
If emergency mental health or chemical dependency care is needed:

- The patient (or a responsible adult, if the patient is incapable) should contact Magellan and indicate that there is an emergency. Magellan will direct the patient to the nearest MHPPO facility for treatment.
- If it is not feasible to contact Magellan in an emergency, the patient should seek treatment at the nearest emergency facility. However, Magellan must be notified:
    - Within 48 hours of treatment or admission; or
    - Within 72 hours of a weekend or holiday treatment or admission.

Expenses for emergency care at a MHPPO facility will be reimbursed at the 80% benefit level for the POS II "B" or 75% for the POS II "A".

If the patient is admitted and the emergency facility does not participate in the MHPPO, Magellan will work with the emergency care treatment team to arrange a transfer to a MHPPO facility as soon as possible after the patient is stabilized. Expenses for emergency care at a non-network MHPPO facility will be reimbursed at the 80% benefit level for the POS II "B" or 75% for the POS II "A".

If you require mental health or chemical dependency care in conjunction with a medical emergency, you must notify Magellan within the time periods described above.

Mental Health PPO

The Mental Health PPO (MHPPO) is a nationwide network of providers who offer quality, cost-effective care. MHPPO providers work with Magellan Behavioral Health to develop suitable treatment plans and provide needed services.

If You Use Mental Health Network Providers
You pay the POS II "A" or "B" primary care co-pay for most outpatient office visits provided by a specialist, which does not apply to the annual deductible. If you need intensive outpatient or inpatient treatment, your covered expenses are reimbursed at 80% for the POS II "B" or 75% for the POS II "A" after the annual deductible is satisfied. There are no limits on the number of inpatient days or outpatient visits per year. The portion of expenses you pay for both inpatient and outpatient care is applied to the annual out-of-pocket limit with the exception of the $500 penalty for failure to pre-certify for inpatient non-network and out-of-network care.

For inpatient mental health and chemical dependency treatment to be reimbursed at the network level, both the provider and the facility must participate in the MHPPO network. If either the provider or the facility is non-network, all expenses associated with the confinement will be reimbursed at the non-network level.

If You Do Not Use Mental Health Network Providers
You should contact Magellan Behavioral Health for pre-certification of non-network care. Remember:

- Magellan can arrange an appointment with an EHAP counselor to discuss needed care and provider selection.
- If you are referred, even in an emergency, by a Medical POS II network provider to a mental health provider, you still must pre-certify with Magellan.

Example — Payment of Network and Non-Network Expenses for Inpatient Mental Health and Chemical Dependency Cases:

Assume you participate in the POS II "B" option and submit a claim for covered inpatient expenses to the Plan. Magellan determines that network charges for your treatment would be $15,000. Also assume that a non-network provider charged $19,000 for the same service. Assume the inpatient hospital deductible of $150 for network and $300 for non-network has been met for the year. Here is how payment of both network and non-network certified and non-certified expenses would compare:

	Certified Network Care	Certified Non-Network Care	Non-Certified Non-Network Care
Total Charges:	$15,000.00	$19,000.00	$19,000.00
Total Covered Charges:	$15,000.00	$15,000.00	$15,000.00
You Pay:	$300.00 (annual deductible)	$300.00 (annual deductible)	$300.00 (annual deductible)
Certified Network Care – 20% of covered charges after the deductible, up to the remaining out-of-pocket limit of $2,700 ($3,000 - $300):	$2,700.00		
Certified Non-network Care – 40% of covered charges after the deductible ($15,000-$300 = $14,700 x 40%):		$5,880.00	
Non-certified, Non-network Care – 40% of covered charges after the deductible ($15,000-$300 = $14,700 x 40% + $500 penalty for no precertification)			$6,380.00
• Expenses exceeding covered charges:		$4,000.00	$4,000.00
Your Total Payment:	**$3,000.00**	**$10,180.00**	**$10,680.00**
The Plan Pays:	**$12,000.00**	**$8,820.00**	**$8,320.00**

Mental Health Care Outside the United States

If you live or travel outside the United States and need treatment for a mental health or chemical dependency condition, **you should contact Magellan Behavioral Health**.

Currently, there are no network providers outside the United States. However, Magellan will recommend providers with whom they have experience. Treatment received is reimbursed at 80% for the POS II "B" and 75% for the POS II "A" after you satisfy the annual deductible. The same emergency care procedures apply inside and outside the United States.

Covered Expenses

Q. What types of medical services are covered by the Plan?

A. The Plan covers a wide range of health care services, tests, treatments, and supplies. For plan purposes, all covered expenses must be medically necessary and not excluded. Generally Aetna's Clinical Policy Bulletins (CPBs) are relied upon to ensure consistent determination of coverage under the Medical Plan. Aetna's CPB's may be viewed online at **www.aetna.com/cpb/cpb_menu.html**.

Covered Expenses (POS II "A" and "B")
Services covered by the Plan are listed below. Services not listed as a covered expense are excluded.

- Acupuncture if performed by a physician.
- Ambulatory surgical center, care, or services. An ambulatory surgical center:
  - Is established, equipped and operated in accordance with applicable local laws primarily for the purpose of performing surgical procedures;
  - Is operated under the full-time supervision of a licensed doctor of medicine or doctor of osteopathy;
  - Permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, has admitting privileges in at least one hospital to perform such a procedure;
  - Has at least two operating rooms and at least one post-anesthesia recovery room, is equipped to perform x-ray and laboratory examinations, and has available trained personnel and necessary equipment, including a defibrillator, a tracheotomy set, and a blood supply, to handle foreseeable emergencies;
  - Provides the full-time services of one or more registered graduate nurses for patient care in operating rooms and in the post-anesthesia recovery room;
  - Maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications or require post-operative confinement; and
  - Maintains appropriate medical records for each patient.
- Braces, crutches and prostheses required because of an injury or disease. Coverage is generally limited to the purchase price.
- Chiropractic services, performed by a licensed doctor of chiropractic who is acting within the scope of his or her license, up to $1,000 per person per year (benefits paid for acupuncture and supplies billed by a doctor of chiropractic are not included in the $1,000 annual maximum).
- Dental work required by an accidental injury to sound, natural teeth or the mouth. Also, certain cutting procedures in the mouth. (See **Dental Treatment** on page 40).
- Diagnosis and treatment of the underlying medical cause of infertility, but infertility services including some services known as Advanced Reproductive Technologies (ART) are not covered unless obtained at an Aetna-designated Institute of Excellence and pre-certified.

- Doctor visits at home, a hospital or an office, including emergency room care.
- Drugs and medicines obtainable only with a physician's prescription and approved by the U.S. Food and Drug Administration for the specific diagnosis.
- Durable medical equipment purchase, rental, repair or replacement. Durable medical equipment includes items such as wheelchairs, hospital beds, mechanical ventilators, and equipment for administering oxygen. A pre-determination is recommended.
- **Extended Care Facility** when pre-certified. (See page 40 for more details).
- Hearing aids. (See **Hearing Aids** on page 41 for more details).
- Home health aides, when pre-certified by Aetna, to provide individualized, non-custodial home care
- Hospice care when pre-certified. (See page 20 for more details).
- Hospital emergency room care, including surgical care and other related charges.
- Hospital semi-private room and board, x-ray and pharmacy, tests and other medical supplies and services received in a hospital.
- Inpatient services performed by surgeons, anesthesiologists, and other physicians.
- Insulin and diabetic supplies received in a doctor's office or an outpatient setting are covered medical expenses. Insulin and diabetic supplies obtained in a retail setting, such as a pharmacy or those obtained by mail order, are covered by Express Scripts.
- Morbid obesity (generally 100% or more over ideal body weight) treatments including physician expenses for the initial office visit and laboratory costs. Contact Aetna Member Services for guidelines regarding eligibility and approved programs for this coverage.
- Network mental health and chemical dependency treatment (both inpatient and outpatient) and out-of-network mental health and chemical dependency treatment (both inpatient and outpatient).
- Nutritional counseling consistent with Aetna's Clinical Policy Bulletins.
- Oral-motor therapy ordered by a physician for treatment of dysphagia or hypotonia.
- Outpatient medical tests and surgery.
- Physical therapy or occupational therapy for treatment of illness, injury or disease, which is performed by a licensed physical or occupational therapist who is acting within the scope of his or her license. If you or your provider anticipates that your current course of therapy may exceed 25 visits, have your physician or therapist submit medical records with each physical therapy claim. Claims for therapy services beyond the 25th visit are subject to medical review. Additional information will be required. Claims will not be paid if the service is found to not be medically necessary.
- Prescription smoking deterrent medications.
- Preventive care services. (See page 25 for details).
- Private-duty nursing care rendered by a nurse when furnished outside of a hospital if such care requires a nurse's services and it is determined that such services are neither primarily custodial in nature nor could be provided by a person other than a nurse.
- Professional emergency transportation services. The Plan pays for medically necessary trips to or from the nearest facility capable of handling the situation. In addition, the Plan pays for transportation to the nearest POS II network facility once the patient is stabilized in a non-network facility.
- Reconstructive surgery including, but not limited to, surgery required because of a mastectomy. The Plan pays benefits for:
    - Reconstructive surgery of the breast on which the surgery was performed.
    - Reconstructive surgery of the other breast in order to produce symmetry.
    - Prostheses for physical complications of mastectomy.

- Services related to the pregnancy of a covered child, but not those related to the child born to the family member.
- Medically necessary procedures to diagnose autism. The treatment of autism spectrum disorder is not covered under the Plan.
- Skilled-nursing care when pre-certified. (See page 41 for more details).
- Speech therapy, on an outpatient basis, to:
    - Restore speech after a demonstrated previous ability to speak is lost or impaired;
    - Improve or develop speech after surgery to correct a birth defect which impaired or would have impaired the ability to speak; or
    - Improve or develop speech lost or impaired by an irreversible and permanent profound hearing loss resulting from a birth defect. (See Speech Therapy under Exclusions. Submission of a proposed treatment plan for a benefit pre-determination is strongly recommended.)
- Sterilization procedures.
- Treatment of temporomandibular disorders, sometimes referred to as "TMJ/TMD," including splints and orthotics. Pre-determination of benefits is strongly recommended.
- Vision examinations and eyeglasses or contact lenses needed because of injury or disease.
- Vision therapy by a physician for amblyopia and strabismus up to a maximum of 32 vision therapy visits or sessions.

Specific Coverage

Comprehensive Infertility Services
Comprehensive infertility services, including some treatments and services known as Advanced Reproductive Technologies (ART), including in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) and frozen embryo transfer (FET), will be covered if obtained at Aetna-designated Institutes of Excellence (IOEs) and pre-certified by calling the National Infertility Unit at 1-800-575-5999. Coverage for this benefit is subject to a $10,000 lifetime limit for each covered person. Comprehensive infertility services also include artificial insemination and ovulation induction, limited to six cycles per lifetime; charges for these cycles do not count toward the $10,000 lifetime limit.

Dental Treatment
Certain dental expenses are covered under the POS II "A" and "B" options. These include charges by a dentist or oral surgeon for treating fractures or dislocations of the jaw or for treating teeth and surrounding tissue damaged because of an injury sustained. Also covered are certain cutting procedures in the mouth, including:

- Impacted and unerupted teeth.
- Removing a tumor.
- Removing or draining an abcess or cyst.
- The alveolar process (alveoplasty and vestibuloplasty).
- Gingivectomy.

Oral surgery procedures covered under the POS II plan are reimbursed at 75% for the POS II “A” and 80% for the POS II “B”, regardless of the provider’s network participation.

For a complete list of oral surgery procedures which may also be considered for payment under the ExxonMobil Dental Plan, consult the ExxonMobil Dental Plan SPD. If you incur dental expenses that may be covered under this option, submit your claim to Aetna Member Services. After determining benefits payable under this option, the claim will be processed as a dental claim (for coordination of benefits) for participants in the ExxonMobil Dental Plan. If you are not a participant in the ExxonMobil Dental Plan, when you receive an explanation of benefits, send the explanation and a copy of your bills along with a claim form to your other dental plan claims office.

Extended-Care Facilities
An extended-care facility provides skilled-nursing services and rehabilitation care. Extended-care facility charges are covered expenses if these conditions are met:

- The confinement must be medically necessary, and
- The confinement has been pre-certified.

Reimbursement is based on the facility charge or daily room and board rate of the hospital from which the patient transferred, whichever is less.

Skilled-nursing Care
Skilled-nursing care is covered if medically necessary and pre-certified. Nursing care that helps a person meet personal needs and daily living activities, such as bathing, dressing, eating or administering oral medication, even if ordered by a physician and performed by a licensed medical professional, is considered custodial and is not a covered expense eligible for benefits. Also, charges for a private-duty nurse in a hospital or an extended-care facility are not covered.

Skilled Care
Skilled care involves nursing or rehabilitation services that can be provided only by licensed medical professionals. For example, intravenous feeding is a skilled service.

Hearing Aids
Benefits are provided up to a maximum of $2,500 after the deductible and co-insurance are paid for one or more medically necessary hearing aids every rolling five year period, which also includes the repair of a hearing aid. However, shipping and handling charges and routine maintenance such as battery replacement are not covered. The amount allowed is subject to reasonable and customary limits but not negotiated rates. There are no Medical POS II preferred providers for hearing aids and related materials. The member will be responsible for the difference between the billed and allowable amount regardless of provider participation.

When you are considering the purchase of hearing aids, you may be able to maximize your benefit through the HearPO® Discount Program. HearPO® locations offer discounts on hearing exams, services and hearing aids. This program is available to Aetna participants. If you go to a participating hearing discount center, your out-of-pocket expenses could be lower. To find a participating hearing discount center location, you can visit www.aetna.com and search DocFind®, or you can log in to Aetna Navigator® and click on “Find a Doctor, Facility or Pharmacy” and then select “Hearing Discount Locations”. To compare costs, please call HearPO® at 1-888-HEARING (1-888-432-7464) and identify yourself as an Aetna member.

Organ, Tissue and Bone Marrow Transplants
Aetna's National Medical Excellence® Program (NME Program) coordinates all aspects of organ, tissue, and bone marrow transplants and other complex specialized care. Providers in this program are recognized as centers of excellence with demonstrated improved outcomes in their area of expertise. In addition, if travel over 100 miles is required, transportation and lodging for the patient and a family member will be covered. The NME Program is separate and distinct from the Centers of Excellence described in the **Partners in Health** section of this SPD.

The NME Program is available on a voluntary basis. Contact Aetna Member Services for information.

Case Management Alternative Treatment Program
If as a result of a catastrophic or chronic illness or injury or in conjunction with certain organ transplant procedures, a participant proposes an alternative course of treatment, the Administrator-Benefits may waive any exclusion or limitation under the Plan which would otherwise apply to covered medical expenses, the reimbursable portions of covered medical expenses or out of pocket limits if such waiver would result in overall cost savings to the Plan. 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. Such approval must be prior to the participant commencing the alternative course of treatment.

Treatment of Last Resort
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.

Exclusions

Q. Are there expenses not covered by the Plan?

A. Although the Plan covers many types of treatments and services, it does not cover all of them. Exclusions shall be interpreted and applied consistently with Clinical Policy Bulletins published by Aetna. These bulletins can be accessed on the Aetna Navigator™ Web site and the Aetna Web site at www.aetna.com. See page 19 for more information.

No benefits are payable under the Plan (POS II "A" and "B") for any charge incurred for:

- Any claim submitted past the claim-filing deadline.
- Any expense incurred before you or your family members became covered under this option (except children less than 31 days old).
- Any expense not recommended and approved by a physician acting within the scope of his or her license.
- Any expenses that exceed reasonable and customary limits.
- Bariatric surgery expenses for the treatment of morbid obesity in excess of the $25,000 lifetime maximum.
- Chelation therapy.
- Chiropractic services for therapeutic purposes in excess of $1,000 per person per year and any maintenance chiropractic care.
- Concierge or annual fees. Any portion not related to medical care (such as a private waiting room, same-day appointments, extended time with physician) is excluded.
- Confinement in a facility that is primarily a school, place of rest, or nursing home.
- Cosmetic surgical procedures, treatments or hospital confinements.
- Custodial care or maintenance care, even if ordered by a physician.
- Dental charges except as specifically provided for on page 40.
- Drugs or vitamins that are available over the counter, even if prescribed by a physician (referred to as legend vitamins, except prenatal vitamins, Rocaltrol)
- Elective abortions
- Experimental or investigational drugs or treatments for a particular diagnosis, other than treatments of last resort.
- Foot orthotics and other supportive devices for feet with the exception of some types of foot braces, even if prescribed by a physician.

- Immunizations/vaccinations obtained outside of a physician's office or hospital, except for the shingles vaccine.
- In-hospital expenses for non-medical items, such as a telephone or television set.
- In-vitro fertilization, embryo transferal, GIFT (Gamete Intra-Fallopian Transfer), ZIFT (Zygote Intra-Fallopian Transfer), artificial insemination or other similar or related procedures, including follow-up testing, to bypass infertility in order to produce pregnancy, unless obtained at an Aetna-designated Institute of Excellence, pre-certified and within the lifetime limit.
- Drugs for infertility associated with ART are not covered under the medical plan but may be covered under the prescription drug program administered by Express Scripts if infertility drugs are authorized by an Aetna-designated Infertility IOE prescriber and approved by Express Scripts.
- Laser-assisted in situ keratomileusis (LASIK), photorefractive keratectomy (PRK), and other similar or related procedures to improve visual acuity. Revision or repeated treatment of surgery is not covered.
- Nutritional programs, weight programs, and related food supplements, except for physician expenses and lab costs for treatment of morbid obesity, and for nutritional counseling performed by a licensed nutritionist or dietician, consistent with Aetna's Clinical Policy Bulletins.
- Nutritional supplements, even if prescribed by a physician, except for treatment of phenylketonuria (PKU).
- Outpatient physical or occupational treatment necessary due to delayed development.
- Outpatient prescription drugs in excess of the allowed supply (34 days for retail and 90 days for mail order) per fill or refill.
- Outpatient speech therapy treatment necessary due to delayed speech development or treatment that is educational rather than restorative in nature.
- Periodic physical examinations paid for by the company.
- Private-duty nursing, except as defined in the **Covered Expenses** section.
- Private room rate above the hospital's most common semiprivate room rate, except where total isolation is medically required and documented in writing by the physician.
- Routine eye examinations, eyeglasses, contact lenses, and orthoptics.
- Self-treatment.
- Treatment, training, education, or behavior modification for Autism Spectrum Disorder.
- Treatment not specifically covered or meeting the Plan's requirements for medical necessity for the care or treatment of a particular disease, injury, or pregnancy.
- Treatment of injuries received or illnesses contracted while on military assignment and covered by a government medical plan.
- Treatment of occupational illnesses or injuries sustained in situations covered by workers' compensation or a similar law.
- Transportation or travel expenses other than emergency transportation service by professional ambulance.
- Voluntary sterilization reversal procedures (including any services for infertility related to voluntary sterilization and its reversal).
- Wigs or hairpieces for androgenic alopecia (male pattern baldness).

Payments

Q. How do the Plan and I share the cost of my health care?

A. You and the Plan share costs for covered treatment and services. You pay a fixed co-payment for covered items such as a POS II network doctor's office visit and emergency room visits. For other types of care, you must satisfy an annual deductible and if applicable, an inpatient hospital deductible before the Plan starts paying. If you meet your annual out-of-pocket limit, the Plan pays 100% of most covered costs for the rest of that calendar year.

Coinsurance

You share in the cost of most medical and mental health and chemical dependency expenses. For some services, such as hospital stays, the coinsurance will be a percentage of the cost of the service once the deductible has been satisfied. For other services, such as office visits to a POS II network provider, the co-payment will be a fixed amount. For outpatient prescription drugs, there is a percentage co-payment.

- **Fixed Co-Payment** —A set amount you pay for covered services or treatments such as POS II doctor's office visits, certain related lab work and x-rays and hospital emergency room visits.
- **Percentage Coinsurance** — This is your share of the cost of certain services or treatments, such as retail and mail-order prescriptions. For medical expenses other than outpatient prescription drugs, once you meet your deductible, you and the Plan share costs until you reach your **out-of-pocket limit** (defined on page 77). Your share is your percentage coinsurance and is typically 20% or 40% for the POS II "B" and 25% or 45% for the POS II "A" depending on the providers you select and whether you live in a network or an out-of-network area. If you reach your annual out-of-pocket limit, the Plan pays 100% of most covered charges for you for the remainder of that calendar year.

Deductible

The deductible is the amount of covered expenses you must pay each calendar year before the Plan begins sharing the cost. Fixed amount co-payments do not apply toward this amount. Outpatient prescription drug percentage co-payments are not subject to nor do they count toward the annual deductible. Services and supplies not provided for a fixed co-payment are subject to an annual deductible, which must be met before the Plan begins to pay.

An additional hospital deductible applies to inpatient hospital services. For network hospitals, it is $150, and for non-network hospitals, the deductible is $300 for the POS II "B" and $250 for network hospitals and $500 for non-network hospitals for the POS II "A".

The deductible for medical, mental health and chemical dependency expenses is currently $300 per year for an individual or $600 per year for a family for the POS II "B" and $500 per year for an individual or $1,000 per year for a family for the POS II "A".

The deductible does not apply to:

- Services and supplies available for a fixed co-payment.
- Outpatient prescription drug expenses.

There are several ways for a family to meet the deductible, including:

- Two covered members of your family each meet the individual deductible.
- One person meets the individual deductible and other members of your family have combined covered charges equaling an individual deductible.
- No one person meets the individual deductible, but the combined covered charges of all members of your family equal the family deductible.

Note: A family deductible cannot be met by only one person.

Charges that Do Not Count Toward the Deductible

- Charges above reasonable and customary levels.
- Charges not covered by the Plan.
- Charge of $500 for failure to pre-certify non-POS II network hospital stays.
- POS II co-payments.
- Any outpatient prescription drug percentage co-payments.
- Charges for a private hospital room above the cost of the hospital's most common rate for a semiprivate room.

The deductible is applied to your claims in the order Aetna processes them, not when the provider collects the money from you. This means if you pay your deductible to one provider, it may not be applied to your annual deductible if Aetna has received and processed other claims first. Please be sure to always get an itemized bill from your provider and retain proof of your payment.

Adjustments to Billed Charges

When providers submit charges for payment, the following factors affect the amount that will be considered eligible for reimbursement. References to these limitations may appear on your explanation of benefits (EOB). Contact Aetna Member Services for more information. A pre-determination of benefits is strongly recommended before you incur any major or unusual expenses.

Reasonable and Customary Limits
Allowable amounts for services are determined by reasonable and customary (R&C) limits. Aetna uses the industry-wide standard for R&C limits obtained from FAIR Health.

R&C limits are based on data from several surrounding regions rather than one specific zip code. R&C limits apply only to non-network providers and services. R&C for services are set at 100% of the range of charges for a particular procedure generally in the same geographic area(s).

Example:
A non-network provider charges $80 for a particular medical procedure, the reasonable and customary limit is $30, and the network provider charge is $25. Only $30 of the $80 charge will be allowed for payment. At the 60% benefit level for the POS II "B" option, the Plan will pay $18 and you will be responsible for paying $12 plus the $50 difference between the reasonable and customary limit and the non-network charge for a total of $62. If you used a Medical POS II provider, you would be charged only the network-negotiated rate of $25 at the 80% network reimbursement level for the POS II "B" option. You would have paid only $5 for the same service.

Incidental Charges
Aetna's current standards for incidental charges are based on the Current Procedural Terminology (CPT) codes and guidelines authored and revised by the American Medical Association since 1966. CPT coding has become the most widely accepted format, by both government and private health insurance programs, in reporting physician procedures. CPT coding furnishes health care providers with a uniform system to accurately describe medical services. CPT coding guidelines explain that services commonly carried out as an integral component of a total service or procedure should not be reported as a separate procedure.

When a claim is submitted with multiple CPT codes, Aetna uses the CPT guidelines to determine whether the charges should be considered as separate costs or if the charges are typically considered as one cost. If Aetna determines that the charges should have been submitted together under one CPT code, the separate charges would be considered incidental to the primary procedure, and the amount allowed for reimbursement would be the amount for the primary procedure.

Example:
Your provider administers an immunization and submits separate charges: one for the medication administered in the immunization and another for administering the shot. In most cases, an immunization should be submitted for payment using one CPT code. If it is submitted as two separate charges, Aetna uses the CPT guidelines and pays only one CPT code for the cost of the medication. The charge for administering the shot is considered to be incidental and is not paid.

Network providers have agreed to accept incidental charges reductions; however, you are responsible for incidental expenses when you use a non-participating provider or if you have signed a statement in the provider's office saying you will be responsible for incidental charges.

Multiple Surgeries (including bilateral procedures)
When multiple surgeries are performed, a health industry standard calculation method is used to reflect the cost savings that accompany services rendered during the same operative session. The amount allowed for multiple procedures performed during the same operative session are as follows:

- 100% for the primary procedure (typically the most complex procedure);
- 50% for the second procedure; and
- 25% for all subsequent procedures.

Example:
You have foot surgery involving three toes on the same foot. The following chart explains how the multiple surgery calculation works if you use a **network** provider and assumes you are enrolled in the POS II "B" option.

A	B	C	D	E
Multiple Surgery Charges Submitted	Multi-Surgery %	Allowed Amount (A X B)	Plan pays at 80% (C X 80%)	You Pay (C - D)
$ 80.00	100%	$ 80.00	$ 64.00	$ 16.00
$ 60.00	50%	$ 30.00	$ 24.00	$ 6.00
$ 40.00	25%	$ 10.00	$ 8.00	$ 2.00
$ 180.00		**$ 120.00**	**$ 96.00**	**$ 24.00**

Note: Network providers have agreed to accept multiple surgery reductions.

Example:
You have foot surgery involving three toes on the same foot. The following chart explains how the multiple surgery calculation works if you use a **non-network** provider and assumes you are enrolled in the POS II "B" option. Procedures performed by a non-network provider are first subject to R&C limits. Those allowed amounts are further reduced by multiple surgery calculations.

A	B	C	D	E
Multiple Surgery Charges Submitted	Multi-Surgery %	Allowed Amount (A X B)	Plan pays at 60% (C X 60%)	You Pay (A - D)
$ 80.00	100%	$ 80.00	$ 48.00	$ 32.00
$ 60.00	50%	$ 30.00	$ 18.00	$ 42.00
$ 40.00	25%	$ 10.00	$ 6.00	$ 34.00
$ 180.00		**$ 120.00**	**$ 72.00**	**$ 108.00**

Surgical Assistants/Assistant Surgeons
If your physician uses a non-physician during a procedure, any charges submitted for the non-physician's services will not be allowed unless a non-physician meets the definition of physician. For the medical treatment or surgical procedures to be considered covered medical expenses, a physician must perform the procedure. See definition of physician under Key Terms.

If your physician is assisted during the procedure by another physician (assistant surgeon), billed charges will be reduced to 25% of the reasonable and customary (R&C) allowance or 25% of the participating fee if in-network for each surgical procedure, according to the allowance for assistant surgeon fees.

Multiple Imaging Diagnostic Tests
When certain multiple imaging diagnostic tests (e.g., MRIs, CT scans, X-rays) are performed on the same date of service, the amount allowed for reimbursement is 100% of the fee schedule (network) or reasonable and customary charge (non-network) for the first diagnostic test and 50% for subsequent tests ordered during a single encounter.

No Volitional Control
Charges incurred if you had no volitional control in determining the provider for emergency ambulance and emergency room physician services will be reimbursed at 80% after the deductible for the POS II "B" and 75% after the deductible for the POS II "A" option, as though a network provider was used.

Non-network charges incurred through the use of a network provider for radiology, anesthesiology, and pathology will also be reimbursed at 80% after the deductible for the POS II "B" and 75% after the deductible for the POS II "A" option, as though a network provider was used. However, charges incurred for non-network radiology, anesthesiology and pathology through non-network providers continue to be reimbursed as non-network.

Reimbursement to non-network providers will be limited to a reasonable and customary amount, rather than billed charges. In the event you are billed for any balance, you may submit the balance to Aetna for additional processing. If you do and you are enrolled in the automatic rollover process to your Health Care Flexible Spending Account (HCFSA), an overpayment from the HCFSA may result from the additional processing. You should contact Aetna to discuss options to return the overpaid HCFSA funds back into the account.

Out-of-Pocket Limits
The annual out-of-pocket limit helps protect participants from high medical costs by increasing the reimbursement level when your payments for covered charges reach certain dollar limits. This limit is separate from the limits established for outpatient prescription drugs. In Medical POS II areas, the limit is different depending on whether you use network or non-network providers.

POS II "A" Option - Annual Out-of-Pocket Limits			
	Your coinsurance		Until you reach your annual out-of-pocket limit of:
If:	**Fixed co-payment:**	**Percentage coinsurance*:**	
You live in a Medical POS II area and:			
Use network providers for medical services	$40 (PCP) or $55 (Specialist)	25%	$4,500 per person $9,000 per family unit
Do not use network providers for medical services	N/A	45%*	$13,500 per person $27,000 per family unit
You do not live in a Medical POS II area and:			
Use network providers for medical services	$40 (PCP) or $55 (Specialist)	25%	$4,500 per person $9,000 per family unit
Do not use network providers for medical services	N/A	25%**	$4,500 per person $9,000 per family unit
For pre-certified mental health care, you:***			
Use mental health network providers	$40	25%	$4,500 per person $9,000 per family unit
Do not use network providers. Magellan's network, not Aetna's, is used for mental health and chemical dependency care.	N/A	45%**	$13,500 per person $27,000 per family unit

* After the annual deductible and, if applicable, the inpatient hospital deductible is met.

** All non-network out-of-pocket expenses are subject to reasonable and customary limits.

*** Call Magellan Behavioral Health for pre-certification. See page 33 for details.

POS II "B" Option - Annual Out-of-Pocket Limits			
	Your coinsurance		Until you reach your annual out-of-pocket limit of:
If:	**Fixed co-payment:**	**Percentage coinsurance*:**	
You live in a Medical POS II area and:			
Use network providers for medical services	$25 (PCP) or $35 (Specialist)	20%	$3,000 per person $6,000 per family unit
Do not use network providers for medical services	N/A	40%*	$12,000 per person $24,000 per family unit
You do not live in a Medical POS II area and:			
Use network providers for medical services	$25 (PCP) or $35 (Specialist)	20%	$3,000 per person $6,000 per family unit
Do not use network providers for medical services	N/A	20%**	$3,000 per person $6,000 per family unit
For pre-certified mental health care, you:***			
Use mental health network providers	$25	20%	$3,000 per person; $6,000 per family unit
Do not use network providers. Magellan's network, not Aetna's, is used for mental health and chemical dependency care.	N/A	40%***	$12,000 per person $24,000 per family unit

* After the annual deductible and, if applicable, the inpatient hospital deductible is met.

** All non-network out-of-pocket expenses are subject to reasonable and customary limits.

*** Call Magellan Behavioral Health for pre-certification. See page 33 for details.

The family out-of-pocket limits work similarly, but the increased reimbursement then applies to you and all of your covered family members — not just the person who met the individual limit.

Using Both Network and Non-Network Providers
If you live in a Medical POS II network area and you choose some network and some non-network providers, the annual out-of-pocket limit works this way:

- Once your annual out-of-pocket total from any provider (network or non-network) reaches $3,000 for an individual (or $6,000 for a family) for the POS II "B" and $4,500 for an individual (or $9,000 for a family) for the POS II "A", the Plan pays 100% of covered expenses when you use network providers. However, at this point, the Plan would still pay only 60% of covered expenses for non-network medical providers.
- Once your out-of-pocket total from any provider (network or non-network) reaches $12,000 for an individual (or $24,000 for a family) for the POS II "B" and $13,500 for an individual (or $27,000 for a family) for the POS II "A", the Plan pays 100% of covered medical expenses when you use a non-network provider.

Expenses That Do Not Count Toward the Out-of-Pocket Limit for Either POS II Option

- Charges above reasonable and customary limits.
- Charges not covered by the Plan.
- Charge of $500 for non-compliance with medical pre-admission review process.
- Charge of $500 for failure to pre-certify inpatient non-network and out-of-network mental health or chemical dependency services.
- Co-payments for outpatient prescription drugs.
- Charges for a private hospital room greater than the cost of the hospital's most common rate for a semiprivate room.

No Lifetime Maximum

There is no maximum lifetime limit on benefits paid by the Plan with the exception of the $25,000 lifetime maximum on bariatric surgery.

Coordination of Benefits

If you are covered by more than one group medical plan (e.g., your spouse's employer's medical plan), you are entitled to coverage from all plans in which you participate, but not to the extent that you collect more than 100% of the amount of the charges.

However, if you or a family member is covered under an individual medical plan (e.g., auto insurance, homeowners insurance personal injury protection, etc), the coordination of benefits provision does not apply.

One of the plans covering you is the primary plan. Claims must be filed first with the primary plan. After the primary plan pays, file the claim with the secondary plan, including a copy of the bills and an explanation of benefits indicating the amount paid by the primary plan.

For example, if you, as an employee or retiree in this option, incur covered expenses, this Plan is primary and your spouse's plan is secondary. However, if your spouse incurs the expenses, his or her plan is primary and this Plan is secondary. This Plan is primary for retirees who are not working, regardless of other coverage under a spouse's plan.

The primary plan always pays benefits first, without considering the other plan. The secondary plan then pays based on its provisions — up to the total allowable expenses covered by that plan or up to the total of all covered expenses.

Refer to page 32 for coordination of benefits provisions for the Prescription Drug Program.

Coverage of a Child
When a child is covered under both parents' plans, the "birthday rule" is used: the plan of the parent whose birthday occurs earlier in the year is the primary plan. The other parent's plan is secondary. If both parents have the same birthday or the spouse's plan has not adopted the birthday rule, the Medical Plan will consider the plan that has covered the child longer as primary.

There are special rules for children of divorced or separated parents. Unless specifically ordered otherwise by a court decree, the plan of the parent with custody, if he or she has not remarried, is primary and the plan of the non-custodial parent is secondary. If the parent with custody remarries, that parent's plan is primary, the stepparent's plan is secondary, and the plan of the non-custodial parent is last.

Retirees Covered by Two Plans
If a retiree covered by the Medical Plan obtains a full-time job in which the retiree is covered by the new employer's medical plan, that plan becomes the primary plan and the Medical Plan is secondary.

When the retiree leaves the last employer, the plan in which the retiree was covered for the longer period becomes the primary plan and the other plan is secondary.

Medicare as Primary
If you or your family member become entitled to Medicare, Medicare is assumed to be the primary plan except in the following circumstances:

- Medicare is secondary for Medicare-eligible employees and their family members who are covered by the Plan through their current employment or the current employment of a spouse.
- Medicare is secondary for employees and their family members who are entitled to Medicare on the basis of permanent disability who are covered under the Plan either through their current employment or the current employment of a family member.
- Medicare is secondary for 30 months for employees and their family members who are entitled to Medicare solely on the basis of end stage renal disease (ESRD) who are covered under the Plan as a result of current employment of the employee or family member.

Payments
If payment for covered medical expenses should have been made under this Plan, but has been made under any other plan, any insurance company or other organization may be reimbursed an amount the Administrator-Benefits determines will satisfy the intent of coordination of benefits provisions. That amount will be considered to be benefits paid under this Plan and shall fully discharge any obligation to make such payments.

Incorrect Computation of Benefits
If you believe that the amount of the benefit you receive from the Medical Plan is incorrect, you should notify Aetna in writing or contact Aetna Member Services.

If it is found that you or a beneficiary were not paid benefits you or your beneficiary were entitled to, the Plan or ExxonMobil will pay the unpaid benefits. (See Claims and Administrative and ERISA Information sections)

Recovery of Overpayment
If the calculation of your or your beneficiary's benefit results in an overpayment, you or your beneficiary will be required to repay the amount of the overpayment to ExxonMobil or the Plan. The plan administrator may make reasonable arrangements with you for repayment.

Claims

Q. When must claims be filed?

A. For an expense to be eligible for reimbursement, the claim must be filed within two years from the date the expense was incurred. An expense is incurred when the services are rendered and not when you are billed.

How to File Claims

The Medical Plan has contracted with Aetna to process claims for medical and mental health care. See Information Sources at the front of this SPD for the address and telephone number.

If you use network providers, they will file claims for you. If your providers do not file claims for you, follow the instructions on the claim forms, which are available from the ExxonMobil Me Intranet site, the ExxonMobil Family Internet site, and Aetna Member Services.

If you have paid a provider's invoice in full and are submitting the invoice to Aetna yourself, please make sure that the claim form is completed and note the following:

- Assignment Section — Do not complete this section or else payment will be made to the provider. Clearly indicate that you, not the provider, should receive the reimbursement.
- Provider bill should clearly state that the bill is "paid in full."

Aetna Member Services reviews and responds to your claim, usually within 30 days after the claim is received. If special circumstances delay the processing of your claim, you will receive written notice telling you why the claim is delayed and when you can expect to receive a decision.

If you need to file a claim:

- Submit a completed claim form with necessary documentation within two years from the date the expense was incurred.
- Aetna will send you an explanation of benefits (EOB) for each claim. The EOB shows what service was performed, how much the provider charged, and what the covered charge was under the Plan. It shows if a deductible or co-payment was involved, as well as the calculation used to determine your benefit.
- Keep the explanation of benefits for your records.
- You can review your EOB by going to Aetna's Navigator Web site at www.aetnanavigator.com and following the instructions.

If you participate in the Pre-Tax Spending Plan Health Care Flexible Spending Account, Aetna processes any reimbursements due you after processing your medical claim. This means that, in most cases, you will not need to file a separate pre-tax claim form for this account.

Outpatient prescription drug purchases from a non-network pharmacy must be filed with Express Scripts. See page 28 for details.

Claim Denial and Reconsideration

If all or part of a claim is denied, Aetna Member Services will provide you with a written explanation supporting the denial and describing additional information, if any, that may improve the claim's likelihood of being approved. See the **Administrative and ERISA Information** section in this SPD.

Right of Reimbursement and Subrogation

If your claim results from an accident or other injury that may be the fault of another party, the Plan will be subrogated to your (or your covered family member's) right of recovery against any party. In addition, you must reimburse any amount paid by the Plan that you recover from any responsible party. The Plan does not require reimbursement from any voluntary medical payments coverage you may carry under your motor vehicle or homeowner's insurance. The Plan will seek reimbursement/subrogation from coverage you may carry for uninsured/underinsured motorists. The Plan's right to subrogation and reimbursement also constitute an "equitable lien" against any payments by any responsible party made or payable to you, your covered family members, or anyone acting on your behalf, now or in the future, regardless of how the payments are characterized. For example, injury, illness or disability related payments that you receive for expenses such as past medical expenses, future medical expenses, attorneys' fees and expenses, or other costs or compensation, up to the full amount of all benefits paid by the Plan, must first be used to repay the Plan before any money goes to you. This creates a priority recovery right in favor of the Plan and is not subject to any application of a "make-whole" or "common fund" rule under local or other law. By accepting benefits from the Plan you are agreeing to this arrangement. The Plan's right to do this is called its right to impose an equitable lien or constructive trust.

You are required to promptly notify the Plan of any occurrence that may give rise to the Plan's reimbursement/subrogation rights and to cooperate with the Plan (or its representative) to secure these rights. Please refer to the Plan's master documents for additional information on the Plan's reimbursement/subrogation rights.

Claims Outside the United States

If you receive medical care when traveling or working outside the United States, generally you must pay the medical bills first. For reimbursement, submit an itemized bill along with a claim form. If the original bills are in a foreign language, you should obtain an English translation, if possible, of the services rendered.

Bills should be submitted in the appropriate foreign currency. The claims administrator will convert the bill to U.S. dollars as of the date of service.

Culture of Health/Partners in Health

Q. What are the Culture of Health and Partners in Health Programs?

A. 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 employees and family members (age 18 and older) eligible to enroll in the ExxonMobil Medical Plan. Retirees who are enrolled in an ExxonMobil 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 Program, Cancer Management Program, and Centers of Excellence. These resources are available to participants in the POS II "A" or "B", Cigna Open Access Plus – In Network, or Aetna Select.

The tools and resources offered through Culture of Health and Partners in Health are available to you free of charge. However, health care claims (e.g., doctor's fees or facilities charges) are processed according to the Plan provisions discussed earlier. (See the sections **How to File Claims**, **Covered Expenses**, and **Exclusions**.)

Health Portal

The Health Portal is an Internet Web gateway to reliable health care information written, 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 (see **Information Sources**) or directly at www.healthyroads.com/xomcultureofhealth.

Health Assessment

This online questionnaire, available 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 Personal 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, if you participate in either POS II option.

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

Highly 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 (see page 43).

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.

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 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 specially 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 call Alere directly at 1-800-557-5519.

Centers of Excellence and Institutes of Excellence

Centers of Excellence (COE) and Institutes of Excellence (IOEs) 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/IOEs are not available for all diseases and all conditions or procedures relevant to a disease state. For instance, at this time there are COEs/IOEs for pancreatic cancer, but there is insufficient information available to select COEs/IOEs for lung cancer. Changes to identified COEs/IOEs may occur in the future.

Participation in a COE/IOE program is voluntary, and designed to direct participants to nationally recognized facilities with more positive outcomes. A COE/IOE-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/IOE. If access to a clinically appropriate COE/IOE requires the patient to travel 100 or more miles, the Medical Plan will reimburse reasonable transportation costs for you and a caregiver. The 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/IOE, you will not incur additional out-of-pocket costs for choosing another hospital in the Plan's network.

Continuation Coverage

Q1. Can coverage be continued after eligibility in this Plan ends?

A1. Yes. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) entitles you and your covered family members to extend medical benefits beyond the date your coverage would normally end.

Q2. What notification time limits must I comply with to begin COBRA for my spouse or my family member?

A2. You are responsible for ending coverage with Benefits Administration when your spouse or family member is no longer eligible for coverage. This must be done as soon as possible. See page 60 for details. In order to be eligible for COBRA, you must notify and provide the appropriate forms to Benefits Administration within 60 days of the event which caused the person to lose eligibility.

Continuation Coverage Rights Under COBRA

Introduction
You are required to be given the information in this section because you are covered under a group health plan (the Plan). This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the 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 Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review this SPD or contact Benefits Administration at the telephone numbers or address listed under **Benefits Administration** on page 62.

IMPORTANT: "Benefits Administration" references throughout this section change depending on your status. Unless specifically stated otherwise, you should refer to the correct Benefits Administration entity using the list below. The contact information for each of these entities is as shown on page 62.

- 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 62.

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 Plan is lost because of the qualifying event. Under the 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 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 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 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 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 in respect to Exxon Mobil Corporation, and the bankruptcy results in a loss of coverage.

When is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the correct Benefits Administration entity 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 the correct Benefits Administration entity of the qualifying event. See page 62 for the listing of Benefits Administration entities.

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 the Benefits Administration entity within 60 days after the later of the date the qualifying event occurs or the date you would lose benefits under the Plan. See page 62 for the listing of Benefits Administration entities. 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 the correct Benefits Administration entity 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 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 62 for the listing of Benefits Administration entities.

You must provide the written determination of disability from the Social Security Administration to the correct Benefits Administration entity 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 62 for the listing of Benefits Administration entities.

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 the correct Benefits Administration entity. 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 . 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 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.

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 Plan Informed of Address Changes
In order to protect your family's rights, you should keep the correct Benefits Administration entity 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.

Benefits Administration

The following sets out the contact numbers based on your status under the ExxonMobil Medical Plan. It is your responsibility to contact the correct Benefits Administration entity 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/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** PO 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** PO Box 2968 Alpharetta, GA 30023-2968



Administrative and ERISA Information

Q. What other information do I need to know about the Plan?

A. This section contains technical information about the Plan and identifies its administrator. It also contains a summary of your rights with respect to the Plan and instructions about how you can submit an appeal if your claim for benefits is denied.

The formal name of the Medical Plan is the ExxonMobil Medical Plan.

Plan Sponsor and Participating Affiliates

The ExxonMobil Medical Plan is sponsored by:

Exxon Mobil Corporation
5959 Las Colinas Blvd
Irving, TX 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.

Basic Plan Information

Plan Administrator

The Plan Administrator for the ExxonMobil Medical Plan is the Administrator-Benefits. The Administrator-Benefits is the Manager-Global Benefits Design, Exxon Mobil Corporation. 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).

Administrator-Benefits
ExxonMobil Medical Plan
P.O. Box 2283
Houston, TX 77252-2283

For service of legal process:
Corporation Service Co.
211 East 7th Street, Suite 620
Austin, Texas 78701-3218

Authority of Administrator-Benefits
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, to construe and interpret the terms of the Medical Plan in its application to any participant or beneficiary, and to decide any and all claim appeals.

Claims Administrator
The claims administrator provides information about claims payment. The claims administrator is Aetna for medical claims and for mental health and chemical dependency claims and Express Scripts for prescription drug claims.

Claims Fiduciary and Appeals
The claims fiduciary is the person to whom all appeals are filed. The claims fiduciary is Aetna for medical mandatory appeals, Magellan Behavioral Health for mandatory and voluntary appeals for all mental health and chemical dependency appeals, and Express Scripts for all prescription drug mandatory and voluntary appeals. The Administrator-Benefits is the claims fiduciary for medical voluntary appeals. You may contact the claims fiduciary as follows:

Medical Mandatory Appeals:	Mandatory and Voluntary Mental Health and Chemical Dependency Appeals:	Prescription Drug Mandatory and Voluntary Appeals:	Medical Voluntary Appeals:
Aetna P.O. Box 14463 Lexington, KY 40512-4463	**Magellan Behavioral Health** P.O. Box 2128 Maryland Heights, Missouri, 63043	**Express Scripts** 8111 Royal Ridge Parkway Irving, TX 75063 Attn: Admin Reviews	**Administrator-Benefits** ExxonMobil Medical Plan P.O. Box 2283 Houston, Texas 77252-2283

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

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

Plan Year
The plan year is the calendar year.

Plan Funding
Benefits are funded through employee and employer contributions. Beginning January 1, 2014, benefits for certain retirees and their family members may be funded from an I.R.C. Section 401(h) account established within the ExxonMobil Pension Plan and Trust.

Benefit Claims Procedures

Filing a Claim
A claim must be filed in writing to the appropriate claims administrator:

- Aetna Member Services for medical, mental health and chemical dependency claims; or,
- Express Scripts for non-network and coordination of benefit prescription drug claims.

The claims administrator is responsible for providing you an explanation of benefits and informing you of your entitlement to a benefit and any amount payable to you.

The following categories of claims for benefits apply to the Medical Plan, and according to the type of claim submitted, your claim will be reviewed and responded to within a designated response time. If additional time (an extension) is needed to decide on your claim because of special circumstances, you will be notified within the claim response period.

If you have a problem with a POS II option benefit, contact Aetna Member Services.

Urgent care claims are claims for medical care or treatment that if normal pre-certification standards were applied would seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function. Also, if in the opinion of a physician with knowledge of the patient's medical conditions the patient would be subjected to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, then a decision would be made according to the urgent care claim response time.

Pre-service claims are any claims for benefits where the Plan provisions require approval before medical care is obtained (e.g., mental health claims, hospital stays).

Post-service claims are claims for benefits where the Plan provisions do not require approval before medical care is obtained. These claims are made after care is received and apply to claims under the Medical Plan. Most claims are post-service claims.

Type of Claim	Response time	Extension
Urgent claims	72 hours	Not applicable. However, if additional information is needed, the claims fiduciary must request the additional information 24 hours after receiving the claim. You must then respond with this additional information within 48 hours of the request. Failure to submit this additional information may result in a claim denial.
Pre-service claims	15 days	An additional 15 days. However, if an extension is necessary due to incomplete information, you must provide the additional information within 45 days from the date of receipt of the extension notice.
Post-service claims	30 days	An additional 15 days. However, if an extension is necessary due to incomplete information, you must provide the additional information within 45 days from the date of receipt of the extension notice.

Denied Claims
If your claim for benefits is denied completely or partially, you, your beneficiary, or designated representative will receive written notice of the decision. The notice will describe:

- The specific reason(s) for the denial.
- Any additional information or material necessary to perfect the claim and an explanation of why such information or material is necessary.
- The process for requesting an appeal.

You should be aware that the claims administrators have the right to request repayment if they overpay a claim for any reason.

Filing a Mandatory Appeal
If your claim is denied, you, your beneficiary, or your designated representative may appeal the decision to the appropriate claims fiduciary. Your written appeal should include the reasons why you believe the benefit should be paid and information that supports, or is relevant to, your claim (written comments, documents, records, etc). Your written appeal may also include a request for reasonable access to, and copies of, all documents, records and other information relevant to your claim. In the case of an urgent care claim, you may request an expedited appeal orally or in writing. You must submit your written appeal within 180 days from the date of the denial notice.

The review will take into account all comments, documents, records and other information submitted relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. You will receive a response to the appeal within a designated response time as follows:

Claim Type	Response Time
Urgent care claims	72 hours
Pre-service claims	30 days
Post-service claims	60 days

If additional time is needed to decide on your claim because of special circumstances, you will be notified within the claim response period. However, an extension may be requested, but the law stipulates that no additional time will be allowed.

If your appeal is denied, you will receive written notice of the decision. The notice will set forth:

- The specific reason(s) for the denial and the Plan provisions upon which the denial is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim.
- A statement of the voluntary appeal procedure and your right to obtain information about such procedure or a description of the voluntary appeal procedure.
- A statement of your right to bring an action under section 502(a) of the Employee Retirement Income Security Act (ERISA).

Statute of Limitations
After you have received the response to the mandatory appeal, you may bring an action under section 502(a) of ERISA. Such action must be filed within one year of the date on which your mandatory appeal was decided. The statute of limitations or other defense based on timeliness is suspended during the time that a voluntary appeal is pending.

Filing a Voluntary Appeal
If your mandatory appeal is denied, you may submit a voluntary appeal. The voluntary appeal must be filed with Express Scripts for prescription drug mandatory appeal denials and Magellan for mental health and chemical dependency mandatory appeal denials. If the voluntary appeal is for a medical appeal denial, it must be filed with the Administrator-Benefits within 30 days of the denial of your mandatory appeal along with new information pertinent to the claim. You will be notified within 15 days after your request was received whether the information was considered new information. If it is determined that there is no new information pertinent to your claim, you will be notified that your voluntary appeal will not be considered. If it is determined that there is new relevant information, a decision will be made within 60 days of the date the Administrator-Benefits receives your request for a voluntary appeal.

No Implied Promises

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

Future of the Medical Plan

ExxonMobil has the right to change, suspend, withdraw, amend, modify or terminate the Plan or any of its provisions at any time and for any reason. A change also may be made to required contributions and future eligibility for coverage, and may apply to those who retired in the past, as well as those who retire in the future. If any material changes are made in the future, you will be notified. For health plans, certain rules apply regarding what happens when a plan is changed, terminated or merged.

Expenses incurred before the effective date of a plan change or termination will not be affected. Expenses incurred after a plan is terminated will not be covered. If a plan cannot pay all of the incurred claims and plan expenses as of the date the plan is changed or terminated, ExxonMobil will make sufficient contributions to the plan to make up the difference. If all claims and expenses are paid and there is still money in ExxonMobil's book reserve established for the purpose of making contributions toward the cost of employees' health care coverage, ExxonMobil will determine what to do with the excess amount in view of the purposes of the plans.

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 as a plan participant, you 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 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 Medical 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.

Assistance with Your Questions
If you have any questions about the Medical Plan, you should contact Aetna Member Services via the telephone number on your ID card, or call Benefits Administration. If you have any questions about this statement or 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.

Federal Notices

Grandfathered Plan Intent
Exxon Mobil Corporation believes that most options available under the ExxonMobil Medical Plan (EMMP) 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 EMMP may not include all consumer protections of the Affordable Care Act that apply to other plans. For example, most options under the EMMP 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 EMMP meets all of the requirements of PPACA.

Questions regarding which protections apply to the EMMP and what might cause the EMMP 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 of 1998
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 Aetna 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.

Key Terms

Barred Employee Close Window
An employee who is covered by a collective bargaining agreement except to the extent participation is provided under such agreement.

Benefit Service Close Window
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 leave 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.

Benefit Pre-Determination Close Window
The review of proposed treatment or services before the expense is incurred to determine if, and to what extent, charges will be covered by the Plan.

Care Manager Close Window
Magellan Behavioral Health or its successor as designated by Exxon Mobil Corporation.

Case Management Close Window
Review provided by medical professionals who consult with the patient and/or care providers to determine effective, cost-efficient ways to treat illnesses and utilize plan benefits.

Change in Status Close Window
Life or work event that allows you to make changes to your elections during the plan year and outside of **Annual Enrollment**.

Child Close Window

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.

Claims Administrator / Processor Close Window

Aetna Life Insurance Company, or affiliates, for claims other than outpatient prescription drugs, and Express Scripts for retail and mail order of outpatient prescription drugs.

Co-Payments and Co-insurance Close Window

Your share of medical (including out-patient prescription drugs) and mental health and chemical dependency expenses. For some services, such as hospital stays, the co-insurance will be a percentage of the cost of the service once the deductible has been satisfied. For other services, such as routine office visits to a POS II provider, the co-payment will be a fixed amount. For outpatient prescription drugs there is a percentage co-payment.

Covered Medical Expense Close Window

- **For treatment of injury or sickness** — a medically necessary expense incurred by a covered person that is not excluded from coverage;
- **For treatment of mental health or chemical dependency** — a medically necessary expense that is certified in advance of actual treatment or an out-of-network inpatient treatment, that is provided according to the terms of the Plan, and that is not otherwise excluded from coverage.

Covered Person Close Window

Any person identified on the books of the employer as a regular employee, retiree, extended part-time employee, eligible family member, or survivor who:

- Complies with the established enrollment requirements and makes any required contributions;
- In the case of a retiree, family member, or survivor, is not eligible for Medicare; and
- Is not eligible for any other medical plan to which ExxonMobil contributes on their behalf.

Custodial Care Close Window

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 Plan.

Deductible Close Window

The amount of covered expenses you must pay each calendar year before the Plan begins sharing the cost. Fixed amount co-payments do not apply toward this amount. Outpatient prescription drug co-payments are not subject to nor do they count toward the annual deductible. Services and supplies not provided for a fixed co-payment are subject to an annual deductible, which must be met before the Plan begins to pay. The deductible is applied to your claims in the order Aetna processes them, not when the provider collects the money from you. This means if you pay your deductible to one provider, it may not be applied to your annual deductible if Aetna has received and processed other claims first. Please be sure to always get an itemized bill and retain proof of your payment, should you need to recover money from your provider.

Eligible Employees Close Window

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 called "regular employees") are eligible. Extended part-time employees, as classified on the employer's books and records, are also eligible.

The following are not eligible to participate in the Plan: leased employees as defined in the Internal Revenue Code, barred employees, or special agreement persons as defined in the 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.

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 a mental disability but who no longer meets the requirements of paragraph 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.

Expatriate Employees Close Window

Expatriate employees include service-oriented employees employed by non-U.S., non-participating employers who are temporarily working in the United States either under a visa that requires coverage by this plan of such employee while in the United States or in an assignment in the United States and the terms of the assignment require proof of adequate medical coverage. Expatriate employees include regular employees working on an assignment outside the United States where the terms of the assignment require proof of adequate medical coverage.

Experimental or Investigational Close Window

A medical treatment or procedure, or a drug, device, or biological product, is experimental or investigational if any of the following apply:

- The drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA); and, approval for marketing has not been given at the time it is furnished; [Note: Approval means all forms of acceptance by the FDA].
- Reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis. Reliable evidence shall mean only:
    - Peer reviewed, published reports and articles in the authoritative medical and scientific literature;
    - The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or biological product or medical treatment or procedure; or
    - The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Explanation of Benefits (EOB) Close Window

The summary you receive after your claim is processed. Codes referred to on the EOB are explained on the document.

Extended-Care Facility Close Window

An institution that meets the following criteria:

- Provides 24-hour skilled nursing care and related services for the rehabilitation of injured or sick persons.
- Has policies developed with the advice of and subject to the review of professional personnel to cover nursing care and related services.
- Has a physician, a registered professional nurse or a medical staff responsible for the execution of such policies.
- Requires that every patient be under the care of a physician and makes a physician available to furnish medical care in an emergency.
- Maintains clinical records on each patient and has appropriate methods for dispensing drugs and biologicals.
- Provides for periodic review by a group of physicians to examine the need for admissions, adequacy of care, duration of stay and the medical necessity of continuing confinement of patients.
- Is licensed pursuant to law or is approved by an appropriate authority as qualifying for licensing.
- Does not include a place that is primarily for custodial care.

Extended Part-Time Employee Close Window

An employee who is classified 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.

ExxonMobil Medical Plan Close Window

The Plan sponsored by Exxon Mobil Corporation which provides medical benefits for eligible employees, retirees, survivors and their family members, and includes the POS II option (described in this SPD).

Hospital Close Window

An institution which:

- Is licensed as a hospital (if licensing is required);
- Is operated pursuant to law for the care and treatment of sick and injured persons;
- Provides 24-hour nursing care and has facilities both for diagnosis and surgery, except in the case of a hospital primarily concerned with the treatment of chronic diseases; and
- Is not a hotel, rest home, nursing home, convalescent home, place for custodial care, or home for the aged.

For purposes of this definition, "hospital" shall also mean, with respect to treatment of substance abuse, a treatment facility, residential facility, or a clinic licensed or approved for such treatment by the appropriate authority for the jurisdiction in which the facility or clinic is located.

Medical Necessity or Medically Necessary Close Window

- Legal;
- Ordered by a physician for medical treatment;
- Reasonably required for the treatment or management of the condition for which it is ordered; and
- Commonly and customarily prescribed by the United States medical community as treatment or management of the condition for which it is ordered.

Magellan Behavioral Health may use its guidelines in an initial determination of whether a mental health service or supply is medically necessary.

The Administrator-Benefits has the exclusive and final authority to determine if a service or supply is medically necessary.

Medical Pre-Certification Close Window
Certification obtained prior to a hospital inpatient stay (including mental health and chemical dependency) to give notice of inpatient admission and the proposed care. If pre-certification notice is not given for inpatient care, the first $500 of expenses will not be covered. Pre-certification is also required for skilled nursing care, home health care, hospice care, some durable medical equipment, complex imaging and certain infertility services obtained at an Aetna-designated Institute of Excellence.

Medical POS II (Point of Service) Close Window
A network of established physicians, hospitals and other medical care providers whose credentials have been screened according to Aetna's standards and who have agreed to provide their services at negotiated rates. The Medical Plan POS II is a network specifically selected by the Plan — it is part of Aetna's Choice® POS II. This network is referred to in this SPD as the Medical POS II.

Mental Health Condition Close Window
Neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or behavioral disorder or disturbance with a diagnosis code from the American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994) (DSM-IV), or its successor publication, and which is appropriately treated by the Mental Health Network. Such a condition will be considered a mental health condition, regardless of any organic or physical cause or contributing factor.

Mental Health Preferred Provider Organization (MHPPO) Close Window
A nationwide network of providers and facilities whose credentials have been screened by Magellan Behavioral Health and who provide treatment for mental health and chemical dependency conditions at negotiated rates.

Mental Health Provider Close Window

A person, including a psychiatrist, psychologist, psychiatric nurse or social worker, therapist, or other clinician with at least a master's degree, who provides inpatient or outpatient treatment for a mental health condition, who is licensed in the state of practice and who is acting within the scope of that license (if applicable). If the person is not subject to a licensing requirement, the person must provide treatment consistent with that which would be provided by the type of providers listed above.

Network Close Window

Providers and facilities that participate in the medical POS II network or mental health PPO network available under the POS II option.

Non-Network Close Window

Providers and facilities located in the medical POS II or mental health PPO network areas, but which do not participate in a network available under this Plan.

Nurse Close Window

A registered graduate nurse (RN), a licensed vocational nurse (LVN), or a licensed practical nurse (LPN).

Out-of-Network Area Close Window

Geographic areas that do not fall within the medical POS II or mental health PPO network.

Out-of-Pocket Limit Close Window

The amount of covered medical expenses you pay in one year before the Plan begins paying 100%. The POS II "A" and "B" options have different out-of-pocket limits. After the out-of-pocket limit is reached, the Plan pays 100% of most covered expenses for the remainder of that year. Certain expenses that you pay do not apply to the out-of-pocket limit. The annual deductible and your percentage co-payments for eligible expenses apply to the out-of-pocket limit. The following charges do not apply to the out-of-pocket limit:

- Charges above reasonable and customary limits.
- Charges not covered by the Plan.
- Charge of $500 for non-compliance with medical pre-admission review process.
- Charge of $500 for failure to pre-certify inpatient non-network and out-of-network mental health or chemical dependency services.
- Co-payments for outpatient prescription drugs.
- Charges for a private hospital room above the cost of the hospital's most common rate for a semiprivate room.

Outpatient Prescription Drug Close Window

A prescription drug or medicine obtained through either a retail pharmacy or through a mail service prescription program (including insulin and associated diabetic supplies if acquired through a prescription). A prescription drug or medicine, including injections, obtained or administered in a physician's office or in a hospital are not considered outpatient prescription drugs.

Physician Close Window

"Physician" means a person acting within the scope of his or her license and holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.), or Doctor of Chiropractic (D.C.), or who is duly licensed as an Orthoptist, a Physician Assistant or Nurse Practitioner. "Primary Care Physician" means a Physician engaged in general practice, family practice, internal medicine, pediatrics or obstetrics/gynecology who provides basic health services to covered persons.

Pre-determination Close Window

A *written* pre-determination request will result in a detailed response as to whether a treatment or service is covered under the Medical Plan and whether the proposed cost is within reasonable and customary limits, thus ensuring all parties are aware of the financial consequences, providing all circumstances described in the request remain unchanged. Please note that a pre-determination, either verbal or written, is not a guarantee of payment, as claims are paid based on the actual services rendered and in accordance with Plan provisions.

Primary Participant Close Window

The term primary participant refers to the participant whose identification number is used. The primary participant is the employee, retiree, survivor or an individual who elected COBRA coverage. Covered family members use the primary participant's identification number to access all medical benefits.

Qualified Medical Child Support Order Close Window

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 Plan's procedures governing QMCSO determinations by written request to the Administrator-Benefits.

Regular Employee Close Window

An employee of a participating employer, whether or not the person is a director, who, as determined by the participating employer, regularly works a full-time schedule, and is not employed on a temporary basis. The definition includes a person who regularly works a full-time schedule but who, for a limited period of time, is approved for a part-time regular work arrangement under the participating employer's work rules relating to part-time work for regular employees.

Retiree Close Window

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 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.

Room and Board Close Window

Room, board, general-duty nursing and any other services regularly furnished by the hospital as a condition of being hospitalized. It does not include professional services of physicians or private-duty nursing.

Spouse; Marriage Close Window

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.

Surgical Procedure Close Window

This term refers to the following:

- A cutting operation.
- Suturing a wound.
- Treating a fracture.
- Reduction of a dislocation.
- Radiotherapy (excluding radioactive isotope therapy) if used in lieu of a cutting operation for removal of a tumor.
- Electrocauterization.
- Diagnostic and therapeutic endoscopic procedures.
- Injection treatment of certain conditions.
- Laser treatments.

Note: Minor procedures such as biopsies or removal of moles or warts, even if performed in a doctor's office, are considered surgery.

Survivor/ Surviving Spouse Close Window

A surviving unmarried spouse or child of a deceased ExxonMobil regular employee or retiree.

Suspended Retiree Close Window

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. A person remains a suspended retiree 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.

The family members of a deceased suspended retiree will be eligible for coverage under this Plan 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.

Treatment of Last Resort Close Window

With respect to a covered person's specific medical condition, any hospital confinement, examination, surgical, medical or other treatment, service or supply that is not determined to be medically necessary for the treatment of such condition by virtue of being experimental or investigative, but that is authorized by the Administrator-Benefits under the following conditions:

A. the covered person's condition is life-threatening; and
B. the treatment is recommended by a treatment panel, which consists of a panel of physicians chosen by the Administrator-Benefits for purposes of reviewing potential treatments of last resort, and which makes such recommendations after considering:
    1. the scientific basis, if any, for the treatment;
    2. the prior use of appropriate treatment alternatives; and
    3. the potential efficacy of the treatment, the patient's physical condition, and the status of any government review of the treatment's use to address such condition.

For purposes of Treatment of Last Resort, a person's condition is considered to be life-threatening if there is a reasonable likelihood that it will result in the person's death within a matter of months or it is likely premature death will occur without early treatment.

Urgent Care Close Window

Conditions or services that are non-preventative or non-routine and needed in order to prevent the serious deterioration of a person's health following an unforeseen illness, injury or condition. Urgent care includes conditions that could not be adequately managed without immediate care or treatment but do not require the level of care provided in an emergency room. Treatment of such a condition outside of an emergency room is paid according to the network status of the provider or facility. For example, out-of-network urgent care furnished by an out-of-network provider or facility is reimbursed at the out-of-network benefit level.

Year Close Window

Calendar year, January 1 through December 31.

Benefit Summary

Please note: These charts provide only a brief summary of benefits under the POS II "A" and POS II "B." They are not intended to include all provisions. Non-network and out-of-network area benefits are subject to reasonable and customary limits.

ExxonMobil Medical Plan
POS II "A" Option
2014 Summary of Benefits
Plan Code: 1021

Service Area: Worldwide
Group Number: 476599
Member Services:
800-255-2386
Provider Website: www.aetna.com
Select Choice® POS II when accessing DocFind®

Services	POS II NETWORK	NON NETWORK	OUT-OF-NETWORK AREA
Annual Deductible (Individual/Family)	$500/$1,000	$600/$1,200	$500/$1,000
Out-of-Pocket Maximum (Individual/Family)	$4,500/$9,000	$13,500/$27,000	$4,500/$9,000
Individual Lifetime Maximum	Unlimited	Unlimited	Unlimited
Separate Lifetime Maximum for Bariatric Surgery	$25,000	$25,000	$25,000
Inpatient Hospital Services[1]	$250 deductible 75% coverage	$500 deductible 55% coverage	$250 deductible 75% coverage
Pre-certification Required for inpatient hospitalization, treatment facility, skilled nursing care, home health care, hospice care & durable medical equipment	Provider initiates	You initiate; $500 penalty for failure to pre-certify inpatient care	You initiate; $500 penalty for failure to pre-certify inpatient care
Outpatient Surgery and Associated Diagnostic Lab and X-ray Services	75% coverage	55% coverage	75% coverage

Physician Services*			
Surgeon/Hospital Doctor Visits	75% coverage	55% coverage	75% coverage
Office Visit (including most diagnostic lab and X-ray services)[2]	Primary care: $40 co-pay[3] Specialist: $55 co-pay[3]	55% coverage	75% coverage
Preventive Care (including most diagnostic lab and X-ray services)[2]	100% coverage	100% coverage	100% coverage

*PCP selection is not required

Prescription Drugs

Annual out-of-pocket maximum for prescription drugs: $2,500 per individual / $5,000 per family

	Retail Co-Pay* ** ***			**Express Scripts Pharmacy****	
	(up to 34-day supply)	**Maximum Per Prescription**	**3rd+ Retail Refill********	**(up to 90-day supply)**	**Maximum Per Prescription**
Generic Drugs	30%	$50	55%	25%	$100
Formulary Brand Drugs	30%	$115	55%	25%	$200
Non-Formulary Brand Drugs	50%	$170	75%	45%	$300

* If using a non-network pharmacy, you pay 100% of the difference between the actual cost and the discounted network cost plus retail co-pays.

** If your doctor prescribes a brand name drug for which a generic equivalent is available, you will be responsible for paying the generic co-pay and the difference in the cost between the brand name and the generic equivalent. The difference in the cost between the brand and the generic does not apply to the annual out-of-pocket maximum for prescription drugs.

*** You must present Express Scripts or Medco Prescription Card or Social Security number of participant or benefits will be paid at the non-network level.

****Additional 25% coinsurance does not apply to the annual out-of-pocket maximum for prescription drugs.

Services	**POS II NETWORK**	**NON NETWORK**	**OUT-OF-NETWORK AREA**
Emergency Care	$75 co-pay[4] 75% coverage	$75 co-pay[4] 75% coverage	$75 co-pay[4] 75% coverage
Maternity	75% coverage	55% coverage	75% coverage
Chiropractic Care	$55 co-pay[3]	55% coverage	75% coverage
• Calendar Year Limit[5]	$1,000	$1,000	$1,000

Mental Health[1]			Overseas only
Inpatient	$250 deductible 75% coverage	$500 deductible 55% coverage	$250 deductible 75% coverage
	Provider initiates precertification	You initiate precertification; $500 penalty for failure to pre-certify inpatient care	You initiate precertification; $500 penalty for failure to pre-certify inpatient care
Outpatient Office Visits	$40 co-pay[3]	55% coverage	75% coverage
Chemical Dependency[1]			Overseas only
Inpatient	$250 deductible 75% coverage	$500 deductible 55% coverage	$250 deductible 75% coverage
	Provider initiates precertification	You initiate precertification; $500 penalty for failure to pre-certify inpatient care	You initiate precertification; $500 penalty for failure to pre-certify inpatient care
Outpatient	$40 co-pay[3]	55% coverage	75% coverage

[1] Pre-certification is required for all inpatient care, including mental health and chemical dependency.

[2] Excludes MRI, CAT scan, PET/Spect, Muga Scan, Thallium stress test, Angiography and Myelography.

[3] Not subject to deductible.

[4] Charge applied to hospital deductible if admitted.

[5] Applies to all chiropractic expenses regardless of network status of provider.

IMPORTANT NOTE: This chart provides only a brief summary of benefits under this option. It is not intended to include all POS II "A" Option provisions.

This information is applicable to all non-represented employees participating in the Medical Plan. Applicability to represented employees is governed by local bargaining requirements.

ExxonMobil Medical Plan
POS II "B" Option
2014 Summary of Benefits
Plan Code: 1022

Service Area: Worldwide
Group Number: 476599
Member Services:
800-255-2386
Provider Website: www.aetna.com
Select Choice® POS II when accessing DocFind®

Services	POS II NETWORK	NON NETWORK	OUT-OF-NETWORK AREA
Annual Deductible (Individual/Family)	$300/$600	$300/$600	$300/$600
Out-of-Pocket Maximum (Individual/Family)	$3,000/$6,000	$12,000/$24,000	$3,000/$6,000
Individual Lifetime Maximum	Unlimited	Unlimited	Unlimited
Separate Lifetime Maximum for Bariatric Surgery	$25,000	$25,000	$25,000
Inpatient Hospital Services[1]	$150 deductible 80% coverage	$300 deductible 60% coverage	$150 deductible 80% coverage
Pre-certification Required for inpatient hospitalization, treatment facility, skilled nursing care, home health care, hospice care & durable medical equipment	Provider initiates	You initiate; $500 penalty for failure to pre-certify inpatient care	You initiate; $500 penalty for failure to pre-certify inpatient care
Outpatient Surgery and Associated Diagnostic Lab and X-ray Services	80% coverage	60% coverage	80% coverage
Physician Services*			
Surgeon/Hospital Doctor Visits	80% coverage	60% coverage	80% coverage
Office Visit (including most diagnostic lab and X-ray services)[2]	Primary care: $25 co-pay[3] Specialist: $35 co-pay[3]	60% coverage	80% coverage
Preventive Care (including most diagnostic lab and X-ray services)2	100% coverage	100% coverage	100% coverage

*PCP selection is not required

Prescription Drugs

Annual out-of-pocket maximums for prescription drugs: $2,500 per individual / $5,000 per family

	Retail Co-Pay* ** ***			Express Scripts Pharmacy**	
	(up to 34-day supply)	Maximum Per Prescription	3rd+ Retail Refill****	(up to 90-day supply)	Maximum Per Prescription
Generic Drugs	30%	$50	55%	25%	$100
Formulary Brand Drugs	30%	$115	55%	25%	$200
Non-Formulary Brand Drugs	50%	$170	75%	45%	$300

* If using a non-network pharmacy, you pay 100% of the difference between the actual cost and the discounted network cost plus retail co-pays.

** If your doctor prescribes a brand name drug for which a generic equivalent is available, you will be responsible for paying the generic copay and the difference in the cost between the brand name and the generic equivalent. The difference in the cost between the brand and the generic does not apply to the annual out-of-pocket maximum for prescription drugs.

*** You must present Express Scripts or Medco Prescription Card or Social Security number of participant or benefits will be paid at the non-network level.

**** Additional 25% coinsurance does not apply to the annual out-of-pocket maximum for prescription drugs.

Services	POS II NETWORK	NON NETWORK	OUT-OF-NETWORK AREA
Emergency Care	$75 co-pay[4] 80% coverage	$75 co-pay[4] 80% coverage	$75 co-pay[4] 80% coverage
Maternity	80% coverage	60% coverage	80% coverage
Chiropractic Care	$35 co-pay[3]	60% coverage	80% coverage
• Calendar Year Limit[5]	$1,000	$1,000	$1,000

Mental Health[1]			Overseas only
Inpatient	$150 deductible 80% coverage	$300 deductible 60% coverage	$150 deductible 80% coverage
	Provider initiates precertification	You initiate precertification; $500 penalty for failure to pre-certify inpatient care	You initiate precertification; $500 penalty for failure to pre-certify inpatient care
Outpatient Office Visits	$25 co-pay[3]	60% coverage	80% coverage
Chemical Dependency[1]			Overseas only
Inpatient	$150 deductible 80% coverage	$300 deductible 60% coverage	$150 deductible 80% coverage
	Provider initiates precertification	You initiate precertification; $500 penalty for failure to pre-certify inpatient care	You initiate precertification; $500 penalty for failure to pre-certify inpatient care
Outpatient	$25 co-pay[3]	60% coverage	80% coverage

[1]Pre-certification is required for all inpatient care, including mental health and chemical dependency care.

[2]Excludes MRI, CAT scan, PET/Spect, Muga Scan, Thallium stress test, Angiography and Myelography.

[3]Not subject to deductible.

[5]Charge applied to hospital deductible if admitted.

[1]Applies to all chiropractic expenses regardless of network status of provider.

IMPORTANT NOTE: This chart provides only a brief summary of benefits under this option. It is not intended to include all POS II "B" Option provisions.

This information is applicable to all non-represented employees participating in the Medical Plan. Applicability to represented employees is governed by local bargaining requirements.

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