

ExxonMobil Medical Plan (EMMP)

Aetna HMO Option (Aetna HMO)

Benefits Information Booklet

Effective Date: January 1, 2010

Welcome!

Our goal is your good health. To achieve this goal, we encourage preventive care in addition to covering you when you are sick or injured. An extensive network of participating physicians and hospitals is available to provide you with easy access to medical care 24 hours a day, 7 days a week.

We believe that through the appropriate use of health resources, we can work together to keep you healthy and to control the rising costs of medical care for everyone.

Your Health Maintenance Organization (HMO) benefits program is self-funded by Exxon Mobil Corporation and administered by Aetna Life Insurance Company (Aetna).*

We wish you the best of health.

**As used in this booklet, "HMO" refers to HMO-type benefits that are self-funded by Exxon Mobil Corporation.*

How to Use Your Benefits Information Booklet

This booklet is your guide to the benefits available through the ExxonMobil Medical Plan Aetna HMO Option (EMMP Aetna HMO, or the Plan). Please read it carefully and refer to it when you need information about how the Plan works, to determine what to do in an emergency situation, and to find out how to handle service issues. It is also an excellent source for learning about many of the special programs available to you as a plan participant.

If you cannot find the answer to your question(s) in the booklet, call the Member Services toll-free number on your ID card. For more information, go to the “Member Services” section in this book.

Tips for New Plan Participants

- Keep this booklet where you can easily refer to it.
- Keep your ID card(s) in your wallet.
- Post your Primary Care Physician’s name and number near the telephone.
- Emergencies are covered anytime, anywhere, 24 hours a day. See “In Case of Medical Emergency” for emergency care guidelines.

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Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-FUNDED BY EXXON MOBIL CORPORATION WHICH IS RESPONSIBLE FOR THEIR PAYMENT. AETNA LIFE INSURANCE COMPANY (AETNA) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT AETNA DOES NOT INSURE THE BENEFITS DESCRIBED.

Eligibility

Most U.S. dollar payroll employees of Exxon Mobil Corporation and participating affiliates who work at a location where the EMMP Aetna HMO is offered and reside in the HMO service area are eligible to participate. The HMO service area is determined by the employee's home address zip code.

Generally you are eligible if:

- You are a regular employee
- You are an Extended Part-time Employee.
- You are a retiree.
- You are a survivor, which means an eligible dependent 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 39.

Eligible Dependents

You may also elect coverage for your eligible dependents including:

- Your spouse. When you enroll your spouse for coverage, you may be required to provide proof that you are legally married.
- Your unmarried dependent child(ren) under age 25 who are not employed on a regular, full-time basis. Coverage ends at the end of the month in which they reach age 25. If your situation involves a dependent other than your biological or legally adopted child who lives with you, call Benefits Administration.
- Your totally and continuously disabled, unmarried dependent 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 dependent 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.

More complete definitions of "Eligible Dependents" and "Dependent Child" appear in the "Glossary" of this booklet and in the definition of "Qualified Medical Child Support Order". If your situation involves a dependent other than your biological or legally adopted child who lives with you, read this information carefully.

Eligibility

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 or receives a lump-sum settlement 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

If you were participating in either the Comprehensive Medical Plan of Mobil Oil Corporation or the Superior Oil Medical Plan on March 31, 2004, you are eligible to elect coverage in the ExxonMobil Medical Plan. In addition, individuals who are eligible dependents may be eligible for coverage.

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 dependents of deceased employees and retirees, spouses and dependents 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 below.

Eligibility

Type of Leave	Leave of Absence Contribution Rate begins		
	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 dependents. 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 dependent. 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.

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 and pre-existing condition provisions do not apply to you and any eligible dependents.

For expatriate employees who are currently enrolled in the Aetna HMO option, coverage for the expatriate employee will change to the POS II option on the first date the employee is scheduled to begin the expatriate assignment.

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 decline this feature. Your monthly pre-tax contributions and class of coverage must remain in effect for the entire plan year, unless you experience a change in status. (See the Changing Your Coverage section on 11).

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 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. However, you and any eligible dependents you enroll may be subject to pre-existing condition provisions.

You can enroll eligible dependents 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 dependents you enrolled were eligible (e.g., marriage certificate, birth certificate). If you fail to provide such requested documents within 90 days of the request, coverage for the dependents will be cancelled retroactively without the refund of any contributions that you made, and you may be asked to repay any benefits that were paid on their behalf from the Medical Plan. In addition, you may be subject to discipline up to and including termination for falsifying company records.

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

Under the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009, effective April 1, 2009, you may change your Plan election for yourself and any eligible dependents 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 enrollment.

Enrollment

CAUTION: SHOULD YOU DECIDE TO RETROACTIVELY CHANGE TO A DIFFERENT MEDICAL PLAN OPTION, SUCH AS FROM AN HMO 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.

If you are paying your contributions through the ExxonMobil Pre-Tax Spending Plan and you do not enroll an eligible dependent within 60 days of your hire date or a change in status, you must wait until the next annual enrollment period.

Annual Enrollment

Each year, usually during the fall, ExxonMobil offers an annual enrollment period. During this time, you can switch from your current coverage option to another available option. For example, you may switch from an HMO option to a POS II option. This is also the time to make changes to your coverage by adding or deleting dependents. Dependents 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. Pre-existing condition provisions may apply to persons added to coverage during Annual Enrollment.

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

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

How the Plan Works

Changing your Coverage

If you pay your contributions on a pre-tax basis and would like to make a coverage change after you are first eligible, you must wait until Annual Enrollment or until you experience one of the following changes in status. If you experience a change in status, you must make the coverage change election within 60 days of the event.

Note: If you are enrolled in the Medical, Dental and/or Vision Plans on an after-tax basis, you may make changes to your Medical Plan coverage level (but not your Medical Plan option) and add eligible dependents at any time; however, pre-existing conditions may apply.

Changes in Status

Changes in status are events that allow you to make changes to your coverage if you pay on a pre-tax basis during the plan year. 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.

Unless you have a relocation that changes your service area or you experience a change as allowed by HIPAA (see How to Enroll section on page 9), you may not change your plan option (e.g., switching between POS II options or to an HMO or from one HMO to another HMO) until the next Annual Enrollment.

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.

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

If this event occurs...	You may...
Marriage	Enroll yourself and spouse and any eligible dependents or change your Medical Plan Option.
Divorce - Employee enrolled in Health Plans	Change your level of coverage. You may not drop coverage for yourself or other covered eligible dependents.
Divorce - Employee loses coverage under spouse's health plans	Enroll yourself and other dependents that might have lost eligibility for spouse's health plans.
Gain a dependent through birth, adoption or placement for adoption, marriage or guardianship	Enroll new dependents and change Medical Plan Option.
Death of a spouse or other eligible dependent.	Change your level of coverage. You may not drop coverage for yourself or other covered eligible dependents.

How the Plan Works

You or a dependent 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 dependents that might have lost eligibility. This only pertains to the Medical Plan. Change your level of coverage and change Medical Plan Option.
Loss of dependent's eligibility (i.e., no longer a tax dependent)	Change your level of coverage. You may not drop coverage for yourself or other eligible dependents.
You lose eligibility because of a change in your employment status, e.g., regular to non-regular	Your Health Plan participation will automatically be terminated 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 dependents in Health Plans.
Termination of Employment by spouse or other dependent or other change in their employment status (e.g., change from full-time to part-time) triggering loss of eligibility under spouse's or dependent's plan in which you or they were enrolled	Enroll yourself and other dependents that may have lost eligibility under the spouse's or dependent's plan in Health Plans and change your Medical Plan Option
Your former spouse is ordered to provide coverage to your children through a QMCSO	End the dependent's coverage, change level of coverage and terminate your participation in Health plans.
Commencement of Employment by spouse or other dependent 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 dependent's coverage and terminate participation in Health Plans if the employee represents that they have or will obtain coverage under the other 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 dependents.
If you, your spouse, or dependent becomes entitled to Medicare or Medicaid	You may cancel coverage for you or the Medicare/Medicaid eligible dependent.
Judgment, decree or other court order requiring you to cover a dependent. (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 Health Plans you had prior to termination
Termination of employment and rehire after 30 days	Enroll in Health Plans 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 dependents in the Health Plans.
You begin a leave of absence	Call Benefits Administration 1-800-262-2363
You return from a leave of absence of more than 30 days (paid or unpaid).	Call Benefits Administration 1-800-262-2363

All changes will be allowed if the medical/dental/vision form is received within 60 days of the event by the Benefits Administration Office or the change is made in EDA within 30 days. For most events, the effective date will be the first of the month after the forms are received or the transaction is completed in EDA. Subject to any

How the Plan Works

enrollment rules applicable to a Medical Plan Option, an employee may add a dependent effective the first day of a month if required contributions are made on a pre-tax basis and adding the dependent does not change the amount of required contributions.

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 dependent 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 provided you complete the enrollment process within 60 days. You must add the new dependent within 60 days even if you already have family coverage. If you do not enroll your new dependents within the first 60 days in the case of birth, adoption or placement for adoption, you can enroll them later during Annual Enrollment (subject to pre-existing conditions) or with another change in status.

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

New Baby?

Even if you already have family coverage, you must complete the enrollment process within 60 days of your baby's birth to add the baby to your coverage. Coverage is then effective as of the baby's date of birth.

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 Dependent Child and the child meets all other requirements of the definition of an eligible dependent, 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. Coverage will be effective as of the first of the month following your completion of the enrollment.

Marriage

If you are enrolled in the Plan, you can enroll your new spouse and his or her eligible dependents (your stepchildren who live with you) for dependent 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 eligible 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. Coverage will be effective as of the first of the month following your completion of the enrollment.

Death of a Spouse

If you lose coverage under your spouse's health plan, you can sign up for medical coverage for yourself and your eligible dependents. 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 dependents are enrolled in the ExxonMobil Medical Plan, any stepchildren who live with you 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 dependent is no longer an eligible dependent (e.g., dependent gets married or gets a full time regular job), coverage continues through the end of the month in which they cease to be eligible. In some cases,

How the Plan Works

continuation coverage under COBRA may be available. (See page 41 for more details about COBRA.) You must notify Benefits Administration as soon as a dependent is no longer eligible. If you fail to notify Benefits Administration within 60 days, any contributions you are making to cover that dependent will continue until the end of the current plan year and the dependent will not be entitled to elect COBRA. You may also be liable for claims paid on behalf of the ineligible dependent as well as liable for falsifying company records.

Divorce

In the case of divorce, your former spouse and any stepchildren are covered through the end of the month in which the divorce is final. You must notify Benefits Administration as soon as your divorce is final. If you fail to notify Benefits Administration within 60 days, any contributions you are making to cover that spouse and dependents will continue until the end of the current plan year and the spouse and dependent will not be entitled to elect COBRA. You may also be liable for claims paid on behalf of the ineligible spouse and dependent as well as liable 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; however, if your stepchildren no longer reside with you after a legal separation, they must be removed as they are no longer eligible to participate in the Medical Plan.

If you lose coverage under your spouse's health plan on account of divorce, you can sign up for medical coverage for yourself and your eligible dependents. 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. Coverage will be effective as of the first of the month following your completion of the enrollment.

Transfer or Change Residence

If you move from one location to another, and the move makes you no longer eligible for the selected Medical Plan option, you may change from your current Medical Plan option to one that is available in your new location. You may not make any other changes. For more information, call Benefits Administration. See Information Sources at the front of this SPD.

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 other types of leaves, you may be subject to pre-existing condition limitations when you return to work and enroll in the Medical Plan if you don't continue your coverage while on leave.

For more information, call Benefits Administration.

How the Plan Works

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 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 dependents. 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. Coverage will be effective as of the first of the month following your completion of the enrollment.

Addition or Improvement of EMMP Options

If a new 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 plan option is discontinued, you will be able to elect either to receive coverage under another plan option providing similar coverage or to drop medical coverage altogether if no similar option is available. For example, if an HMO is discontinued, you may elect another HMO that has service in your area or you may elect to participate in the POS II option. You may also elect to 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 medical 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 EMMP Aetna HMO offers service in that area. If your covered family member does not live with you, please contact Member Services to confirm whether service is available. (See "Service Area" in the "Glossary".)

If You are a Retiree Under Age 65

If you are a retiree under age 65, you and your dependents who are not eligible for Medicare can continue to participate in the Plan. When you (as a retiree) or a covered dependent becomes eligible for Medicare, Medicare will become the primary plan and benefits will be coordinated. You then are no longer eligible for the Medical Plan, but you are eligible to enroll in the EMMSP.

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 Plan. You may be eligible to elect continuation coverage for yourself and your eligible dependents under COBRA provisions. See page 41 for details.

How the Plan Works

If You Work Past Age 65

If you continue to work for ExxonMobil past age 65, although you are eligible for Medicare, your ExxonMobil coverage remains in effect for you and eligible dependents and the Medical Plan is your primary plan. Medicare benefits, if you sign up for them, will be your secondary benefits.

If You or Your Covered Dependents Become Medicare Eligible for Any Reason

Employees or dependents 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 dependents must change to the ExxonMobil Medicare Supplement Plan and enroll in Medicare Parts A and B. If you become Medicare eligible and do not enroll in the ExxonMobil Medicare Supplement Plan, you will be responsible for any claim expenses you incur from the date of your Medicare eligibility.

When a retiree or a retiree's covered eligible dependent becomes eligible for Medicare, either due to age or Social Security disability status, that person cannot participate in any Medical Plan option but will be eligible for the ExxonMobil Medicare Supplement Plan

If You Die

If you die while enrolled, your covered eligible dependents 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 dependent. If your surviving spouse remarries, eligibility for your children also ends. Special rules may apply to dependents of individuals who become retirees due to disability. See Suspended Retiree below.

Eligible dependents of deceased extended part-time employees are not eligible to continue to participate in the Plan. These dependents may be eligible to elect continuation coverage under COBRA provisions. See page 41 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 dependents who were eligible for 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.

How the Plan Works

Plan participants have access to a network of participating Primary Care Physicians (PCPs), specialists and hospitals that meet Aetna's requirements for quality and service. These providers are independent physicians and facilities that are monitored for quality of care, patient satisfaction, cost-effectiveness of treatment, office standards and ongoing training.

Each participant in the Plan must select a Primary Care Physician (PCP) when they enroll. Your PCP serves as your guide to care in today's complex medical system and will coordinate and monitor your overall care.

The Primary Care Physician

As a participant in the Plan, you will become a partner with your participating PCP in preventive medicine. Consult your PCP whenever you have questions about your health. Your PCP will provide your primary care and, when medically necessary, your PCP will refer you to other doctors or facilities for treatment. The referral is important because it is how your PCP arranges for you to receive necessary, appropriate care and follow-up treatment. Except for PCP, direct access and emergency services, **you must have a prior written or electronic referral from your PCP to receive coverage for all services and any necessary follow-up treatment.**

Participating specialists are required to send reports back to your PCP to keep your PCP informed of any treatment plans ordered by the specialist.

Primary and Preventive Care

Your PCP can provide preventive care and treat you for illnesses and injuries. The Plan covers routine physical exams, well-baby care, immunizations and allergy shots provided by your PCP.

You may also obtain routine vision exams, and gynecological exams from participating providers without a referral from your PCP. You are responsible for the co-payment shown in the "Co-payment Schedule."

How the Plan Works

Specialty and Facility Care

Your PCP may refer you to a specialist or facility for treatment or for covered preventive care services, when medically necessary. **Except for those benefits described in this booklet as direct access benefits and emergency care, you must have a prior written or electronic referral from your PCP in order to receive coverage for any services the specialist or facility provides.**

When your PCP refers you to a participating specialist or facility for covered services, you will be responsible for the co-payment shown in the “Co-payment Schedule.”

To avoid costly and unnecessary bills, follow these steps:

- **Consult your PCP first** when you need routine medical care. If your PCP deems it medically necessary, you will get a written or electronic referral to a participating specialist or facility. If the referral is for multiple visits, the first visit must be within 90 days of the referral date and the remaining visits must be used within one year of the date the referral was issued, unless a different timeframe is specified, as long as you remain an eligible participant in the Plan. For direct access benefits, you may contact the participating provider directly, without a referral.
- Certain services require **both** a referral from your PCP **and** prior authorization from Aetna. Your PCP is responsible for obtaining authorization from Aetna for in-network covered services.
- **Review the referral** with your PCP. Understand what specialist services are being recommended and why.
- Present the referral to the participating provider. Except for direct access benefits, any additional treatments or tests that are covered benefits require another referral from your PCP. The referral is necessary to have these services approved for payment. **Without the referral, you are responsible for payment for these services.**
- If it is not an emergency and you go to a doctor or facility **without your PCP’s prior written or electronic referral, you must pay the bill yourself.**
- Your PCP may refer you to a nonparticipating provider for covered services that are not available within the network. Services from nonparticipating providers require prior approval by Aetna in addition to a special nonparticipating referral from your PCP. When properly authorized, these services are covered after the applicable co-payment.

Remember, you cannot request referrals **after** you visit a specialist or hospital. Therefore, to receive maximum coverage, you need to contact your PCP and get authorization from Aetna (when applicable) **before** seeking specialty or hospital care.

Some PCPs are affiliated with integrated delivery systems (IDS) or other provider groups (such as Independent Practice Associations and Physician-Hospital Associations). If your PCP participates in such an arrangement, you will usually be referred to specialists and hospitals within that system or group. However, if your medical needs extend beyond the scope of the affiliated providers, you may ask to have services provided by non-affiliated physicians or facilities. Services provided by non-affiliated providers may require prior authorization from Aetna and/or the IDS or other provider group. Check with your PCP or call the Member Services number that appears on your ID card to find out if prior authorization is necessary.

How the Plan Works

Specialist as Principal Physician Direct Access Program

If you have a serious or complex medical condition, you may need ongoing specialty care. A “serious or complex medical condition” is generally a life-threatening, degenerative or disabling condition or disease such as AIDS, cancer, emphysema, an organ failure that may require a transplant, or diabetes with target organ involvement.

The Specialist as Principal Physician Direct Access Program is a voluntary program. Eligibility is based upon the nature of your medical condition, your need for continuing specialty care and a specialist’s willingness to serve as your principal physician for treatment of the condition.

Enrollment in the program must be approved by Aetna. Once you are enrolled, a case manager will be available to answer questions about the features of the program, to assist with any necessary authorizations or pre-certifications and to facilitate communications between your PCP and the specialist treating your condition.

If you are interested in enrolling in the Specialist as Principal Physician Direct Access Program, contact Member Services at the toll-free number shown on your ID card and ask to be transferred to a disease management representative.

Provider Information

A listing of network providers is provided automatically. You may also obtain, without charge, this listing of network providers from the Administrator-Benefits, or by calling the toll-free Member Services number on your ID card.

It is easy to obtain information about providers in Aetna’s network using the Internet. With DocFind® you can conduct an online search for participating doctors, hospitals and other providers. To use DocFind, go to **www.aetna.com/docfind**. Select the appropriate provider category and follow the instructions provided to select a provider based on specialty, geographic location and/or hospital affiliation. If you live in Texas and participate in the Aetna HMO, the name of your option on your membership card is the PCP Referral Plan. When using DocFind, select Standard Plans and then select PCP Referral Plan to search for a network provider. If you live in another state and participate in the Aetna HMO, select Standard Plans and then select HMO to search for network providers.

Your ID Card

When you join the Plan, you and each enrolled member of your family receive a member ID card. Your ID card lists the telephone number of the Aetna PCP you have chosen. If you change your PCP, you automatically will receive a new card displaying the change.

Always carry your ID card with you. It identifies you as a plan participant when you receive services from participating providers or when you receive emergency services at non-participating facilities. When you obtain a prescription at a participating pharmacy, remember to present your ID card. If your card is lost or stolen, please notify Aetna immediately.

Partners in Health

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 Health Portal, a Health Assessment, a 24-Hour Nurse Line, Health Advocate Program, Disease Management Programs, Tobacco Cessation Program, Weight Management Program, Cancer Management Program and Centers of Excellence. The Health Portal and Health Assessment are available to all eligible employees, retirees, and dependents (age 18 and older). The remaining resources are available to participants in the EMMP Aetna HMO.

The tools and resources offered through 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.

Health Portal

The Health portal is an Internet Web gateway to reliable health care information reviewed and approved by the medical staff of the Mayo Clinic. This Internet site is filled with useful health and health care information including the following:

- **Feature Articles** — Feature articles updated regularly.
- **Reference Resources** — Information resources covering diseases, conditions and medications.
- **Answers from Specialists** — Growing library of user questions with answers from Mayo Clinic specialists.
- **Information Centers** — Information resources focused on specific lifestyle or condition-related topics such as asthma, cancer, or nutrition.
- **Programs** — Interactive programs including self-assessments, goal-setting, and tracking tools related to specific lifestyle issues or conditions such as weight management, exercise, or asthma.

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

Health Assessment

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

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

The Mayo Clinic 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.

Partners in Health

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. The nurse may refer you to a Health Advocate for a more detailed conversation if you face a health risk or serious medical condition.

Health Advocate Program

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

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

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

Disease Management Program

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

- Heart Failure.
- Cardiovascular Disease.
- Diabetes.
- Musculoskeletal & Pain Management (MSCP).
- Chronic Obstructive Pulmonary Disease (COPD)

Partners in Health

Healthyroads[®] Tobacco Cessation Program

Participants over the age of 18 may self-enroll in a phone-based program that will offer support and educational tools to develop tailored quit plans for individuals who use tobacco by calling (877) 330-2746.

Healthyroads[®] Weight Management Program

This is a referral only program for participants over the age of 18 who meet specific body mass index and comorbidity criteria. Referrals are made through the Health Advocate or Disease Management Programs described above.

Cancer Management Program

If you are undergoing active cancer treatment, you may be referred to a specifically trained cancer management nurse through your Health Advocate or Disease Management nurse. Referrals will be made to provide support to those undergoing treatment.

Centers of Excellence

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

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

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

Whenever clinically appropriate, you will be referred to a local COE. If access to a clinically appropriate COE requires the patient to travel 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, you will not incur additional out-of-pocket costs for choosing another hospital in the Plan's network.

2010 Co-payment Schedule

All non-emergency specialty and hospital services require a prior referral from your PCP, unless noted below as a “direct access” benefit.

Type of Service or Supply	Benefit Level
Lifetime Maximum	No lifetime maximum
Primary And Preventive Care	
PCP Office Visits	\$20 co-pay per visit
After Hours/Home Visits/Emergency Visits	\$20 co-pay per visit
Routine Examinations	\$20 co-pay per visit
Routine Child and Well-Baby Care	\$20 co-pay per visit
Immunizations	\$20 co-pay per visit
Prostate Screening	\$20 co-pay – one annual prostate screening for men age 40 and over
Allergy Treatment- Routine injections at PCP’s office, with or without physician encounter	\$20 co-pay per visit
Routine Eye Examinations	\$20 co-pay per visit - direct access (no referral) to participating providers for periodic routine exams If you wear eyeglasses or contact lenses: age 1-18 years - one exam every 12 months. age 19 or over - one exam every 24 months. If you do not wear eyeglasses or contact lenses: age 1-44 years - one exam every 36 months. age 45 or over - one exam every 24 months.
Eyeglasses/Contact Lenses	\$100 lens and frame reimbursement amount per 24-month period Discounts available through Aetna Vision Discount Program
Routine Hearing Screenings	Covered when performed as part of a routine exam by PCP. Subject to office visit co-pay.
Hearing Aids	Not covered
Specialty And Outpatient Care	
Specialist Office Visits	\$30 co-pay per visit
Walk in Clinic (Retail Clinic)	\$30 co-pay per visit
Prenatal Care	\$30 co-pay for the first OB visit
Maternity	\$75 hospital deductible
Routine Gynecological Exams	\$30 co-pay per visit - direct access (no referral) to participating providers for one routine exam and Pap smear per 365-day period
Routine Mammogram	\$30 co-pay - one annual mammogram for women age 40 and over
Infertility Services	\$30 co-pay per visit
Allergy Testing	\$30 co-pay per visit
X-rays and Lab Tests	\$30 co-pay
Therapy (speech, occupational, physical)	\$30 co-pay per visit
Chiropractic Care	\$30 co-pay per visit - 20 visits per year
Outpatient Rehabilitation	\$30 co-pay per visit

2010 Co-payment Schedule

Type of Service or Supply	Benefit Level
Home Health Care	No co-pay
Hospice Care	No co-pay
Durable Medical Equipment (DME)	No co-pay - must be approved in advance by Aetna
Prosthetic Devices	No co-pay - some prostheses must be approved in advance by Aetna

Inpatient Services	
Hospital Room and Board and Other Inpatient Services	\$75 deductible
Skilled Nursing Facilities	\$75 deductible
Hospice Facility	\$75 deductible

Surgery And Anesthesia	
Inpatient Surgery	\$75 deductible
Outpatient Surgery	\$35 co-pay - outpatient facility \$30 co-pay - specialist's office

Mental And Nervous Conditions	
Inpatient Treatment	\$75 deductible
Outpatient Treatment	\$20 co-pay per visit

Treatment Of Alcohol And Drug Abuse	
Inpatient Detoxification and Rehabilitation	\$75 deductible
Outpatient Detoxification and Rehabilitation	\$20 co-pay per visit

Emergency Care	
Emergency Room	\$75 co-pay (waived if admitted)
Ambulance	No co-pay when medically necessary
Urgent Care	\$25 per visit

Prescription Drugs	
Annual out-of-pocket maximum	No annual maximum benefit \$2,500 - per member
Retail (30-day supply) \$120 maximum per prescription	\$15 co-pay – generic formulary drugs 30% co-pay – brand-name formulary drugs 40% co-pay – non-formulary drugs
Mail Order (90-day supply) \$120 maximum per prescription	\$30 co-pay – generic formulary drugs 30% co-pay – brand-name formulary drugs 40% co-pay – non-formulary drugs

Your Benefits

Although a specific service may be listed as a covered benefit, it may not be covered unless it is **medically necessary** for the prevention, diagnosis or treatment of your illness or condition. Refer to the “Glossary” section for the definition of “medically necessary.”

Certain services must be precertified by Aetna. Your participating provider is responsible for obtaining this approval.

Primary and Preventive Care

One of the Plan’s goals is to help you maintain good health through preventive care. Routine exams, immunizations and well-child care contribute to good health and are covered by the Plan (after any applicable co-payment) if provided by your PCP or on referral from your PCP:

- Office visits with your PCP during office hours and during non-office hours.
- Home visits by your PCP.
- Treatment for illness and injury.
- Routine physical examinations, as recommended by your PCP.
- Well-child care from birth, including immunizations and booster doses, as recommended by your PCP.
- Health education counseling and information.
- Annual prostate screening (PSA) and digital exam for males age 40 and over, and for males considered to be at high risk who are under age 40, as directed by physician.
- Routine gynecological examinations and Pap smears performed by your PCP. You may also visit a participating gynecologist for a routine GYN exam and Pap smear without a referral.
- Routine mammograms for female plan participants age 35 or over.
- Annual mammography screening for asymptomatic women age 40 and older. Annual screening is covered for younger women who are judged to be at high risk by their PCP. Note: Diagnostic mammography for women with signs or symptoms of breast disease is covered as medically necessary.
- Colorectal cancer screening for those age 50 and older and at normal risk for developing colon cancer.
- Bone mass measurement to determine an individual's risk of osteoporosis.
- Routine immunizations (except those required for travel or work).
- Periodic eye examinations. You may visit a participating provider without a referral as follows:
 - *If you wear eyeglasses or contact lenses:*
 - age 1-18 years - one exam every 12 months.
 - age 19 or over - one exam every 24 months.
 - *If you do not wear eyeglasses or contact lenses:*
 - age 1-44 years - one exam every 36 months.
 - age 45 or over - one exam every 24 months.
- Prescription lenses and frames, including contact lenses, subject to any allowances shown in the “Co-payment Schedule.”
- Routine hearing screenings performed by your PCP as part of a routine physical examination.
- Injections, including routine allergy desensitization injections.

Your Benefits

Specialty and Outpatient Care

The Plan covers the following specialty and outpatient services. You must have a prior written or electronic referral from your PCP in order to receive coverage for any non-emergency services the specialist or facility provides.

- Participating specialist office visits.
- Participating specialist consultations, including second opinions.
- Outpatient surgery for a covered surgical procedure when furnished by a participating outpatient surgery center.
- Preoperative and postoperative care.
- Casts and dressings.
- Radiation therapy.
- Cancer chemotherapy.
- Short-term speech, occupational (except vocational rehabilitation and employment counseling), and physical therapy for treatment of non-chronic conditions and acute illness or injury.
- Cognitive therapy associated with physical rehabilitation for treatment of non-chronic conditions and acute illness or injury.
- Short-term cardiac rehabilitation provided on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Short-term pulmonary rehabilitation provided on an outpatient basis for the treatment of reversible pulmonary disease.
- Diagnostic, laboratory and imaging services, including X-rays.
- Emergency care including ambulance service - 24 hours a day, 7 days a week (see “In Case of Emergency”).
- Home health services provided by a participating home health care agency, including:
 - skilled nursing services provided or supervised by a RN.
 - services of a home health aide for skilled care.
 - medical social services provided or supervised by a qualified physician or social worker if your PCP certifies that the medical social services are necessary for the treatment of your medical condition.
 - Medically necessary physical, speech, and hearing, or occupational therapy is covered.
- Outpatient hospice services for a plan participant who is terminally ill, including:
 - counseling and emotional support.
 - home visits by nurses and social workers.
 - pain management and symptom control.
 - instruction and supervision of a family member.
 - Note: The Plan does not cover the following hospice services:
 - bereavement counseling, funeral arrangements, pastoral counseling, or financial or legal counseling.
 - homemaker or caretaker services and any service not solely related to the care of the terminally ill patient.
 - respite care when the patient’s family or usual caretaker cannot, or will not, attend to the patient’s needs.
- Oral surgery (limited to extraction of bony, impacted teeth, treatment of bone fractures, removal of tumors and odontogenic cysts).
- Reconstructive breast surgery following a mastectomy, including:
 - reconstruction of the breast on which the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant,
 - surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed, and

Your Benefits

- physical therapy to treat the complications of the mastectomy, including lymphedema.
- Infertility services to diagnose and treat the underlying medical cause of infertility. You may obtain the following basic infertility services from a participating gynecologist or infertility specialist without a referral from your PCP:
 - initial evaluation, including history, physical exam and laboratory studies performed at an appropriate participating laboratory,
 - evaluation of ovulatory function,
 - ultrasound of ovaries at an appropriate participating radiology facility,
 - postcoital test,
 - hysterosalpingogram,
 - endometrial biopsy, and
 - hysteroscopy.
- Semen analysis at an appropriate participating laboratory is covered for male plan participants; a referral from your PCP is necessary.
- If you do not conceive after receiving the above infertility services, or if the diagnosis suggests that there is no reasonable chance of pregnancy as a result of the above services, you are eligible to receive the following comprehensive services through a participating infertility specialist when preauthorized through and coordinated by the Aetna Infertility Unit:
 - ovulation induction cycles (bloodwork and ultrasounds), subject to a lifetime maximum of 6 cycles,
 - artificial insemination, subject to a lifetime maximum of 6 attempts, and
 - infertility surgery (diagnostic or therapeutic).
- Chiropractic services. Subluxation services must be consistent with Aetna's guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation that could be documented by diagnostic X-rays performed by a participating radiologist.
- Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth). Instruction and appropriate services required to ensure proper use of equipment (such as attachment or insertion). Certain prosthetics require preauthorization by Aetna.
- Durable medical equipment (DME), prescribed by a physician for the treatment of an illness or injury, and preauthorized by Aetna. The Plan covers instruction and appropriate services required for the plan participant to properly use the item, such as attachment or insertion, if approved by Aetna. Replacement, repair and maintenance are covered only if:
 - they are needed due to a change in your physical condition, or
 - it is likely to cost less to buy a replacement than to repair the existing equipment or rent like equipment.The request for any type of DME must be made by your physician and in some cases coordinated through the Aetna Patient Management Department.

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.

Your Benefits

Inpatient Care in a Hospital, Skilled Nursing Facility or Hospice

If you are hospitalized by a participating PCP or specialist (with prior referral except in emergencies), you receive the benefits listed below. See “Behavioral Health” for inpatient mental health and substance abuse benefits.

- Confinement in semi-private accommodations (or private room when medically necessary and certified by your PCP) while confined to an acute care facility.
- Confinement in semi-private accommodations in an extended care/skilled nursing facility.
- Confinement in semi-private accommodations in a hospice care facility for a plan participant who is diagnosed as terminally ill.
- Intensive or special care facilities.
- Visits by your PCP while you are confined.
- General nursing care.
- Surgical, medical and obstetrical services provided by the participating hospital.
- Use of operating rooms and related facilities.
- Medical and surgical dressings, supplies, casts and splints.
- Drugs and medications.
- Intravenous injections and solutions.
- Administration and processing of blood, processing fees and fees related to autologous blood donations. (The blood or blood product itself is not covered.)
- Nuclear medicine.
- Preoperative care and postoperative care.
- Anesthesia and anesthesia services.
- Oxygen and oxygen therapy.
- Inpatient physical and rehabilitation therapy, including:
 - cardiac rehabilitation, and
 - pulmonary rehabilitation.
- X-rays (other than dental X-rays), laboratory testing and diagnostic services.
- Magnetic resonance imaging.
- Non-experimental, non-investigational transplants. All transplants must be ordered by your PCP and participating specialist and approved in advance by Aetna. Transplants must be performed in hospitals specifically approved and designated by Aetna to perform the procedure. The Institutes of Excellence (IOE) network is Aetna's network of providers for transplants and transplant-related services, including evaluation and follow-up care. Each facility has been selected to perform only certain types of transplants, based on their quality of care and successful clinical outcomes. A transplant will be covered only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any facility that is not specified as an Institute of Excellence network facility is considered as an out-of-network facility for transplant-related services, even if the facility is considered as a participating facility for other types of services.

Maternity Care

The Plan covers physician and hospital care for mother and baby, including prenatal care, delivery and postpartum care. In accordance with the Newborn and Mothers Healthcare Protection Act, you and your newly born child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery (96 hours following a cesarean section). However, your provider may – **after consulting with you** – discharge you earlier than 48 hours after a vaginal delivery (96 hours following a cesarean section).

Your Benefits

You do not need a referral from your PCP for visits to your participating obstetrician. A list of participating obstetricians can be found in your provider directory or on DocFind (see “Provider Information”).

Note: Your participating obstetrician is responsible for obtaining pre-certification from Aetna for all obstetrical care after your first visit. They must request approval (pre-certification) for any tests performed outside of their office and for visits to other specialists. Please verify that the necessary referral has been obtained before receiving such services.

If you are pregnant at the time you join the Plan, you receive coverage for authorized care from participating providers **on and after your effective date**. There is no waiting period. Coverage for services incurred prior to your effective date with the Plan is your responsibility or that of your previous plan.

Behavioral Health

Your mental health/substance abuse benefits will be provided by participating behavioral health providers. You do not need a referral from your PCP to obtain care from participating mental health and substance abuse providers. Instead, when you need mental health or substance abuse treatment, call the behavioral health telephone number shown on your ID card. A clinical care manager will assess your situation and refer you to participating providers, as needed.

Mental Health Treatment

The Plan covers the following services for mental health treatment:

- Inpatient medical, nursing, counseling and therapeutic services in a hospital or non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent.
- Short-term evaluation and crisis intervention mental health services provided on an outpatient basis.

Treatment of Alcohol and Drug Abuse

The Plan covers the following services for treatment of alcohol and drug abuse:

- Inpatient care for detoxification, including medical treatment and referral services for substance abuse or addiction.
- Inpatient medical, nursing, counseling and therapeutic rehabilitation services for treatment of alcohol or drug abuse or dependency in an appropriately licensed facility.
- Outpatient visits for substance abuse detoxification. Benefits include diagnosis, medical treatment and medical referral services by your PCP.
- Outpatient visits to a participating behavioral health provider for diagnostic, medical or therapeutic rehabilitation services for substance abuse.
- Outpatient treatment for substance abuse or dependency must be provided in accordance with an individualized treatment plan.

Prescription Drugs

The Plan pays, subject to any limitations specified under “Your Benefits,” the cost incurred for outpatient prescription drugs that are obtained from a participating pharmacy. You must present your ID card and make the co-payment shown in the “Co-payment Schedule” for each prescription at the time the prescription is dispensed.

Your Benefits

The Plan covers the costs of prescription drugs, in excess of the co-payment, that are:

- Medically necessary for the care and treatment of an illness or injury, as determined by Aetna;
- Prescribed in writing by a physician who is licensed to prescribe federal legend prescription drugs or medicines; and
- Not listed under “Prescription Drug Exclusions and Limitations,” below.

Each prescription is limited to a maximum 30-day supply, with refills as authorized by your physician (but not to exceed one year from the date originally prescribed). Non-emergency prescriptions must be filled at a participating pharmacy. Generic drugs may be substituted for brand-name products where permitted by law.

Coverage is based upon Aetna’s formulary. The formulary includes both brand-name and generic drugs and is designed to provide access to quality, affordable outpatient prescription drug benefits. You can reduce your co-payment by using a covered generic or brand-name drug that appears on the formulary. Your co-payment will be highest if your physician prescribes a covered drug that does not appear on the formulary.

Mail Order Drugs

Participants in the Plan who must take a drug for more than 30 days may obtain up to a 90-day supply of the drug with Aetna RX Home Delivery (www.aetnarxhomedelivery.com), if authorized by their physician. The minimum quantity dispensed by Aetna RX Home Delivery is for a 31-day supply, and the maximum quantity is for a 90-day supply. The co-payment shown in the “Co-payment Schedule” will apply to each mail order purchase.

Emergency Prescriptions

You may not have access to a participating pharmacy in an emergency or urgent care situation, or if you are traveling outside of the Plan’s service area. If you must have a prescription filled in such situations, the Plan will reimburse you as follows:

- **Non-Participating Pharmacy** - Coverage for items obtained from a non-participating pharmacy is limited to items connected to covered emergency or out-of-area urgent care services. You must pay the pharmacy directly for the cost of the prescription. You are responsible for submitting a written request for reimbursement to Aetna, accompanied by the receipt for the prescription. Contact Member Services for more information. Aetna will review your request and determine whether the event meets the qualifications for reimbursement. If approved, you will be reimbursed for the cost, minus any applicable co-payment.
- **Participating Pharmacy** - When you obtain an emergency or urgent care prescription at a participating pharmacy (including an out-of-area participating pharmacy), you must pay the co-pay. Aetna will not reimburse you if you submit a claim for a prescription obtained at a participating pharmacy.

Covered Drugs

The Plan covers the following:

- Outpatient prescription drugs when prescribed by a provider who is licensed to prescribe federal legend drugs or medicines, subject to the terms, limitations and exclusions described in this booklet.
- FDA-approved prescription drugs when the off-label use of the drug has not been approved by the FDA to treat the condition in question, provided that:

Your Benefits

- the drug is recognized for treatment of the condition in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or
- the safety and effectiveness of use for the condition has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.
- Diabetic supplies, as follows:
 - diabetic needles and syringes.
 - alcohol swabs.
 - test strips for glucose monitoring and/or visual reading.
 - diabetic test agents.
 - lancets (and lancing devices).
 - insulin.
 - prescriptive and nonprescriptive oral agents for controlling blood sugar levels.
 - glucagon emergency kits.
- Smoking Cessation aids and drugs prescribed by a physician.
- Oral and implantable contraceptive drugs and contraceptive devices.
- Injectable contraceptives (Depo-Provera).

Prescription Drug Exclusions and Limitations

Prescription Drug Exclusions

The following services and supplies are **not** covered by the Plan, and a medical exception is not available for coverage:

- Any drug that does not, by federal or state law, require a prescription order (such as an over-the-counter drug), even when a prescription is written.
- Any drug that is not medically necessary.
- Charges for the administration or injection of a prescription drug or insulin.
- Cosmetics and any drugs used for cosmetic purposes or to promote hair growth, including (but not limited to) health and beauty aids.
- Any prescription for which the actual charge to you is less than the co-payment.
- Any prescription for which no charge is made to you.
- Insulin pumps or tubing for insulin pumps.
- Medication which is to be taken by you or administered to you, in whole or part, while you are a patient in a licensed hospital or similar facility.
- Take-home prescriptions dispensed from a hospital pharmacy upon discharge from the hospital, unless the hospital pharmacy is a participating retail pharmacy.
- Any medication that is consumed or administered at the place where it is dispensed.
- Immunization or immunological agents, including, but not limited to:
 - biological sera.
 - blood, blood plasma or other blood products administered on an outpatient basis.
 - allergy sera and testing materials.
- Drugs used for the purpose of weight reduction, including the treatment of obesity.
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.
- Drugs labeled "Caution - Limited by Federal Law to Investigational Use" and experimental drugs.
- Drugs prescribed for uses other than the uses approved by the FDA under the Food, Drug and Cosmetic Law and regulations.

Your Benefits

- Medical supplies, devices and equipment, and non-medical supplies and substances, regardless of their intended use.
- Prescription drugs purchased prior to the effective date, or after the termination date, of coverage under this Plan.
- Replacement of lost or stolen prescriptions.
- Drugs used to aid or enhance sexual performance, including (but not limited to):
 - sildenafil citrate (e.g. Viagra), phentolamine, apomorphine and alprostadil in oral, injectable, and topical (including but not limited to gels, creams, ointments and patches) forms, and
 - any prescription drug in oral, topical, or any other form that is in a similar or identical class, has a similar or identical mode of action, or exhibits similar or identical outcomes, unless otherwise covered under this plan.
- Performance, athletic performance, or lifestyle-enhancement drugs and supplies.
- Smoking-cessation aids or drugs unless prescribed by a physician.
- Growth hormones.
- Test agents and devices, except diabetic test strips.
- Needles and syringes, except diabetic needles and syringes.
- Any drug or device that terminates a pregnancy.
- Prophylactic drugs for travel.
- Nutritional Supplements.
- Medication packaged in unit dose form (except those approved by payment by Aetna).
- Injectable drugs, except insulin. The Plan does not cover:
 - injectable drugs used in the treatment of infertility.

Prescription Drug Limitations

The following limitations apply to the prescription drug coverage:

- A participating retail or mail order pharmacy may refuse to fill a prescription order or refill when, in the professional judgment of the pharmacist, the prescription should not be filled.
- Prescriptions may be filled only at a participating retail or mail order pharmacy, except in the event of emergency or urgent care. Plan participants will not be reimbursed for out-of-pocket prescription purchases from a non-participating pharmacy in non-emergency, non-urgent care situations.
- Plan participants must present their ID cards at the time each prescription is filled to verify coverage. If you do not present your ID card, your purchase may not be covered by the Plan, except in emergency and urgent care situations, and you may be required to pay the entire cost of the prescription.
- The plan is not responsible for the cost of any prescription drug for which the actual charge to the plan participant is less than the required co-payment or for any drug for which no charge is made to the recipient.
- Plan participants will be charged the non-formulary prescription drugs co-payment for prescription drugs covered on an exception basis.

Exclusions and Limitations

Exclusions

The Plan does not cover the following services and supplies:

- Acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery.
- Ambulance services, when used as routine transportation to receive inpatient or outpatient services.
- Any service in connection with, or required by, a procedure or benefit not covered by the Plan.
- Any services or supplies that are not medically necessary, as determined by Aetna.
- Biofeedback, except as specifically approved by Aetna.
- Blood, blood plasma, or other blood derivatives or substitutes.
- Breast augmentation and otoplasties, including treatment of gynecomastia.
- Canceled office visits or missed appointments.
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. However, the Plan covers the following:
 - reconstructive surgery to correct the results of an injury.
 - surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function.
 - surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.
- Court-ordered services and services required by court order as a condition of parole or probation, unless medically necessary and provided by participating providers upon referral from your PCP.
- Custodial care and rest cures.
- Dental care and treatment, including (but not limited to):
 - care, filling, removal or replacement of teeth,
 - dental services related to the gums,
 - apicoectomy (dental root resection),
 - orthodontics,
 - root canal treatment,
 - soft tissue impactions,
 - alveolectomy,
 - augmentation and vestibuloplasty treatment of periodontal disease,
 - prosthetic restoration of dental implants, and
 - dental implants.However, the Plan does cover oral surgery as described under “Your Benefits.”
- Educational services, special education, remedial education or job training. The Plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training or cognitive rehabilitation. Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and developmental delays are not covered by the Plan.
- Expenses that are the legal responsibility of Medicare or a third party payor.

Exclusions and Limitations

- Experimental and investigational services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by Aetna, unless approved by Aetna in advance. This exclusion will not apply to drugs:
 - that have been granted treatment investigational new drug (IND) or Group c/treatment IND status,
 - that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, or
 - that Aetna has determined, based upon scientific evidence, demonstrate effectiveness or show promise of being effective for the disease.Refer to the “Glossary” for a definition of “experimental or investigational.”
- Hair analysis.
- Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated.
- Hearing aids, eyeglasses, or contact lenses or the fitting thereof, except as specified under “Your Benefits.”
- Home births.
- Home uterine activity monitoring.
- Household equipment, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, is not covered. Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides and swimming pools, are not covered.
- Hypnotherapy, except when approved in advance by Aetna.
- Implantable drugs.
- Infertility services, except as described under “Your Benefits.” The Plan does not cover:
 - purchase of donor sperm and any charges for the storage of sperm.
 - purchase of donor eggs, and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers.
 - cryopreservation and storage of cryopreserved embryos.
 - all charges associated with a gestational carrier program (surrogate parenting) for the plan participant or the gestational carrier.
 - drugs related to the treatment of non-covered benefits or related to the treatment of infertility that are not medically necessary.
 - injectable infertility drugs.
 - the costs for home ovulation prediction kits.
 - services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal.
 - services for females with FSH levels greater than 19 mIU/ml on day 3 of the menstrual cycle.
 - donor egg retrieval or fees associated with donor egg programs, including but not limited to laboratory tests.
 - any charges associated with a frozen embryo transfer, including but no limited to thawing charges.
 - any new technology used in an Experimental or Investigational program.
 - any service provided by a non-participating provider or, in the case of Comprehensive Infertility Services, without a prior referral or claim authorization from the Infertility Program case management unit.
 - any advanced reproductive technology (ART) procedures or services related to such procedures, including without limitation in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and intracytoplasmic sperm injection (ICSI).
 - any charges associated with care required for advanced reproductive therapy (e.g. office, hospital, etc..).
 - any charges associated with obtaining sperm for ant advanced reproductive therapy.

Exclusions and Limitations

- Inpatient care for Serious Mental Illness which is not provided in a Hospital or Mental Health Treatment Facility.
- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
- Orthotics.
- Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings and reagent strips, (except as described under “Prescription Drugs”).
- Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services.
- Private duty or special nursing care, unless pre-authorized.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including related services and treatment.
- Reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.
- Routine hand and foot care services, including routine reduction of nails, calluses and corns.
- Services not covered by the Plan, even when your PCP has issued a referral for those services.
- Services or supplies covered by any automobile insurance policy, up to the policy’s amount of coverage limitation.
- Services provided by your close relative (your spouse, child, brother, sister, or the parent of you or your spouse) for which, in the absence of coverage, no charge would be made.
- Services required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with:
 - obtaining or continuing employment,
 - obtaining or maintaining any license issued by a municipality, state or federal government,
 - securing insurance coverage,
 - travel, and
 - school admissions or attendance, including examinations required to participate in athletics, unless the service is considered to be part of an appropriate schedule of wellness services.
- Services and supplies that are not medically necessary.
- Services you are not legally obligated to pay for in the absence of this coverage.
- Special education, including lessons in sign language to instruct a plan participant whose ability to speak has been lost or impaired to function without that ability.
- Special medical reports, including those not directly related to the medical treatment of a plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.
- Specific injectable drugs, including:
 - experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA and the National Institutes of Health,
 - needles, syringes and other injectable aids (except as described under “Prescription Drugs”),
 - drugs related to treatments not covered by the Plan, and
 - drugs related to the treatment of infertility, contraception, and performance-enhancing steroids.
- Specific non-standard allergy services and supplies, including (but not limited to):
 - skin titration (wrinkle method),
 - cytotoxicity testing (Bryan’s Test),
 - treatment of non-specific candida sensitivity, and
 - urine autoinjections.

Exclusions and Limitations

- Speech therapy for treatment of delays in speech development, unless resulting from disease, injury, or congenital defects.
- Surgical operations, procedures or treatment of obesity, except when approved in advance by Aetna. Bariatric surgery is excluded in all events and will not be pre-authorized.
- Therapy or rehabilitation, including (but not limited to):
 - primal therapy.
 - chelation therapy.
 - rolfing.
 - psychodrama.
 - megavitamin therapy.
 - purging.
 - bioenergetic therapy.
 - vision perception training.
 - carbon dioxide therapy.
- Thermograms and thermography.
- Transsexual surgery, sex change or transformation. The Plan does not cover any procedure, treatment or related service designed to alter a plan participant's physical characteristics from their biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
- Treatment in a federal, state or governmental facility, including care and treatment provided in a nonparticipating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment, including therapy, supplies and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Treatment of diseases, injuries or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.
- Treatment of injuries sustained while committing a felony.
- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services or medical treatment of the retarded individual as described under "Your Benefits."
- Treatment of sickness or injury covered by a worker's compensation act or occupational disease law, or by United States Longshoreman's and Harbor Worker's Compensation Act.
- Treatment of temporomandibular joint (TMJ) syndrome, including (but not limited to):
 - treatment performed by placing a prosthesis directly on the teeth,
 - surgical and non-surgical medical and dental services, and
 - diagnostic or therapeutic services related to TMJ.
- Weight reduction programs and dietary supplements.

Limitations

In the event there are two or more alternative medical services that, in the sole judgment of Aetna, are equivalent in quality of care, your coverage may be limited to the least costly service, as determined by Aetna, provided that Aetna approves coverage for the service or treatment in advance.

In Case of Medical Emergency

Guidelines

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. Aetna has adopted the following definition of an emergency medical condition from the Balanced Budget Act (BBA) of 1997:

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- *Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;*
- *Serious impairment to bodily function; or*
- *Serious dysfunction of any bodily organ or part.*

Some examples of emergencies are:

- Heart attack or suspected heart attack.
- Poisoning.
- Severe shortness of breath.
- Uncontrolled or severe bleeding.
- Suspected overdose of medication.
- Severe burns.
- High fever (especially in infants).
- Loss of consciousness.

For both medical and mental health/substance abuse emergencies, whether you are in or out of Aetna's service area we ask that you follow the guidelines below when you believe you may need emergency care.

1. Call your PCP first, if possible (in the case of mental health and substance abuse emergency care participants should call the behavioral health telephone number on their ID card as soon as reasonably possible and a clinical care manager will assist with next steps). Your PCP is required to provide urgent care and emergency coverage 24 hours a day, including weekends and holidays. **However, if a delay would be detrimental to your health, seek the nearest emergency facility, or dial 911 or your local emergency response service.**
2. After assessing and stabilizing your condition, the emergency facility should contact your PCP so they can assist the treating physician by supplying information about your medical history.
3. If you are admitted to an inpatient facility, notify your PCP as soon as reasonably possible. The emergency room co-payment will be waived if you are admitted to the hospital.
4. All follow-up care must be coordinated by your PCP.
5. If you go to an emergency facility for treatment that Aetna determines is non-emergency in nature, you will be responsible for the bill. The Plan does not cover non-emergency use of the emergency room.

In Case of Medical Emergency

Follow-Up Care after Emergencies

All follow-up care should be coordinated by your PCP. You must have a referral from your PCP **and** approval from Aetna to receive follow-up care from a nonparticipating provider. Whether you were treated inside or outside your Aetna service area, you must obtain a referral before any follow-up care can be covered. Suture removal, cast removal, X-rays, and clinic and emergency room revisits are some examples of follow-up care.

Urgent Care

Treatment that you obtain outside of your service area for an urgent medical condition is covered if:

- The service is a covered benefit;
- You could not reasonably have anticipated the need for the care prior to leaving the network service area; and
- A delay in receiving care until you could return and obtain care from a participating network provider would have caused serious deterioration in your health.

Some examples of urgent medical conditions are:

- Severe vomiting.
- Earaches.
- Sore throat.
- Fever.

Follow-up care provided by your PCP is covered, subject to the office visit co-payment. Other follow-up care by participating specialists is fully covered with a **prior written or electronic referral** from your PCP, subject to the specialist co-payment shown in the “Co-payment Schedule.”

What to Do Outside Your Aetna Service Area

Plan participants who are traveling outside the service area, or students who are away at school, are covered for emergency care and treatment of urgent medical conditions. Urgent care may be obtained from a private practice physician, a walk-in clinic, or an urgent care center. An urgent medical condition that occurs outside your Aetna service area can be treated in any of the above settings. You should call your PCP before receiving treatment from a non-participating urgent care provider.

If, after reviewing information submitted to Aetna by the provider(s) who supplied your care, the nature of the urgent or emergency problem does not clearly qualify for coverage, it may be necessary to provide additional information. Aetna will send you an Emergency Room Notification Report or a customer service professional (CSP) can take this information over the telephone.

When Coverage Ends

Coverage for you and/or your dependents 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 dependent ceases to be eligible (for example, a dependent child reaches age 25);
 - 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 dependent;
 - You, as a retiree, or your eligible dependent 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 are responsible for ending coverage with Benefits Administration when your enrolled spouse or dependent is no longer eligible for coverage. If you do not complete your change within 60 days, any contributions you make for ineligible dependents will not be refunded and your pre-tax contributions cannot be reduced until the next plan year or a subsequent change in status. Any claims paid after the loss of eligibility must be repaid by you.

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.

A participant's coverage under the EMMP Aetna HMO may be terminated for cause. "For cause" is defined as:

- **Untenable relationship:** After reasonable efforts, Aetna and/or the Plan's participating providers are unable to establish and maintain a satisfactory provider-patient relationship with you or a plan participant of your family. You will be given 31 days advance written notice of the termination of coverage.
- **Failure to make co-payments:** You or a member of your family fails to make any required co-payment or any other payment that you are obligated to pay. You will be given 31 days advance written notice of the termination of coverage.
- **Refusal to provide Coordination of Benefits (COB) information:** You or a member of your family refuses to cooperate and provide any facts necessary for Aetna to administer the Plan's COB provision. You will be given 31 days advance written notice of the termination of coverage.

When Coverage Ends

- **Furnishing incorrect or incomplete information:** You or a member of your family willfully furnishes incorrect or incomplete information in a statement made for the purpose of enrolling in, or obtaining benefits from, the Plan. Termination of coverage under the EMMP Aetna HMO will be effective immediately.
- **Fraud against the Plan:** This may include, but is not limited to, allowing a person who is not a participant of the Plan to use your Aetna ID card. Termination of coverage under the EMMP Aetna HMO will be effective immediately.
- **Misconduct:** You or a covered member of your family abuses the system, including (but not limited to) theft, damage to the property of a participating provider, or forgery of drug prescriptions. Termination of coverage under the EMMP Aetna HMO will be effective immediately.

No benefits will be provided to you and your family members once coverage is terminated for cause.

Any termination for cause is subject to review in accordance with the Plan's grievance process.

You may request that Aetna conduct a grievance hearing within 15 working days after receiving notice that coverage has been or will be terminated. Coverage will be continued until a final decision on the grievance is rendered, provided you continue to make required contributions. Termination may be retroactive to the original date of termination if the final decision is in favor of Aetna.

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 dependents may be available through COBRA.

Portability of Coverage

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

Continuation of Coverage

Introduction

You are required to be given the information in this section because you are covered under a group health plan (the 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 ExxonMobil Benefits Administration/ Health Plan Services at the telephone numbers or address listed under Benefits Administration on page 45.

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.

- Current ExxonMobil employees or their dependents refer to ExxonMobil Benefits Administration/ Health Plan Services;
- Exxon, or Mobil, or Superior Oil, or ExxonMobil retirees, or their survivors or their dependents refer to Mobil Benefits Service Center; and
- Former Exxon or ExxonMobil employees, or retirees, or their survivors, or their dependents, 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 45.

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 dependent 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.

Continuation of Coverage

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.

Dependent 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 dependent child.

Any retiree, retiree's spouse (including surviving spouse), and dependent 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 45 for the listing of Benefits Administration entities.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or a dependent child's losing eligibility for coverage as a dependent child), you must notify the correct 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 45 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.

Continuation of Coverage

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 dependent child's losing eligibility as a dependent child, 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 45 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 45 for the listing of Benefits Administration entities.

Continuation of Coverage

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 dependent 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 dependent 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 dependent child stops being eligible under the Plan as a dependent child. This extension is available only if the qualifying event would have caused the spouse or dependent 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 dependents. You should also keep a copy, for your records, of any notices you send to Benefits Administration.

Continuation of Coverage

Contacts for COBRA rights under the ExxonMobil Medical Plan

The following sets out the contact numbers based on your status under the ExxonMobil Medical Plan. It is your responsibility to contact 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:
<ul style="list-style-type: none"> • Employees and their dependents, call: <p>ExxonMobil Benefits Administration/Health Plan Services Monday - Friday 8:00 a.m. to 3:00 p.m. (U.S. Central Time), except certain holidays</p> <p>713-680-5858 (Houston) 713-680-7070 (international, call collect) 800-262-2363 (toll free outside Houston)</p>	<p>ExxonMobil Benefits Administration ATTN: Health Plan Services ExxonMobil BA BSC USBA 4300 Dacoma or "BH1" Houston, TX 77092</p>
<ul style="list-style-type: none"> • Retirees and Survivors call: <p>ExxonMobil Benefits Service Center Monday - Friday 8:00 a.m. to 6:00 p.m. (U.S. Eastern Time), except certain holidays</p> <p>800-682-2847 800-TDD-TDD4 (833-8334) for the hearing impaired</p>	<p>ExxonMobil Benefits Service Center P.O. Box 1014 Totowa, NJ 07512-1014</p>
<ul style="list-style-type: none"> • Former Exxon or ExxonMobil Employees, Exxon or ExxonMobil Retirees, or their Survivor or their Dependents, who elected and are participating through COBRA, call: <p>ExxonMobil COBRA Administration Monday - Friday 8:00 a.m. to 8:00 p.m. (U.S. Central Time), except certain holidays</p> <p>800-522-6621 770-619-7160 (fax)</p>	<p>ADP Benefit Services ADP National Accounts ExxonMobil COBRA Administration P.O. Box 2968 Alpharetta, GA 30023-2968</p>

Claims

Coordination of Benefits

If you have coverage under other group plans, the benefits from the other plans will be taken into account if you have a claim. This may mean a reduction in benefits under the EMMP.

Benefits available through other group plans and/or no-fault automobile coverage will be coordinated with the EMMP. "Other group plans" include any other plan of dental or medical coverage provided by:

- Group insurance or any other arrangement of group coverage for individuals, whether or not the plan is insured; and
- "No-fault" and traditional "fault" auto insurance, including medical payments coverage provided on other than a group basis, to the extent allowed by law.

To find out if benefits under the EMMP will be reduced, Aetna must first determine which plan pays benefits first. The determination of which plan pays first is made as follows:

- The plan without a coordination of benefits (COB) provision determines its benefits before the plan that has such a provision.
- The plan that covers a person other than as a dependent determines its benefits before the plan that covers the person as a dependent. If the person is eligible for Medicare and is not actively working, the Medicare Secondary Payer rules will apply. Under the Medicare Secondary Payer rules, the order of benefits will be determined as follows:
 - The plan that covers the person as a dependent of a working spouse will pay first;
 - Medicare will pay second; and
 - The plan that covers the person as a retired employee will pay third.
- Except for children of divorced or separated parents, the plan of the parent whose birthday occurs earlier in the calendar year pays first. When both parents' birthdays occur on the same day, the plan that has covered the parent the longest pays first. If the other plan doesn't have the parent birthday rule, the other plan's COB rule applies.
- When the parents of a dependent child are divorced or separated:
 - If there is a court decree which states that the parents will share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the parent birthday rule, immediately above, applies.
 - If a court decree gives financial responsibility for the child's medical, dental or other health care expenses to one of the parents, the plan covering the child as that parent's dependent determines its benefits before any other plan that covers the child as a dependent.
 - If there is no such court decree, the order of benefits will be determined as follows:
 - the plan of the natural parent with whom the child resides,
 - the plan of the stepparent with whom the child resides,
 - the plan of the natural parent with whom the child does not reside, or
 - the plan of the stepparent with whom the child does not reside.
- If an individual has coverage as an active employee or dependent of such employee, and also as retired or laid-off employee, the plan that covers the individual as an active employee or dependent of such employee is primary.
- The benefits of a plan which covers a person under a right of continuation under federal or state laws will be determined after the benefits of any other plan which does not cover the person under a right of continuation.
- If the above rules do not establish an order of payment, the plan that has covered the person for the longest time will pay benefits first.

Claims

If it is determined that the other plan pays first, the benefits paid under the EMMP will be reduced. Aetna will calculate this reduced amount as follows:

- The amount normally reimbursed for covered benefits under the EMMP,
Less
- Benefits payable from your other plan(s).

If your other plan(s) provides benefits in the form of services rather than cash payments, the cash value of the services will be used in the calculation.

Right of Recovery (Subrogation and/or Reimbursement)

If you or a covered family member receives benefits from this plan as the result of an illness or injury caused by another person, the EMMP has the right to be reimbursed for those benefits from any settlement or payment you receive from the person who caused the illness or injury. This means the EMMP may recover costs from all sources (including insurance coverage) potentially responsible for making any payment to you or your covered dependent as a result of an injury or illness, including:

- Uninsured motorist coverage;
- Underinsured motorist coverage;
- Personal umbrella coverage;
- Med-pay coverage;
- Workers' Compensation coverage;
- No-fault automobile coverage; or
- Any first party insurance coverage

What You Need to Know

Here are some important points about the right of subrogation:

The Plan has a lien on any payments you receive.

The EMMP automatically has a lien, to the extent of any benefits it has paid, on any payment you've received from a third party, his/her insurer or any other source. The lien is in the amount of benefits paid by Aetna under this plan for treatment of the illness, injury or condition for which the other person is responsible.

Your cooperation is required.

You may not do anything to interfere or affect the EMMP's subrogation rights.

You also must fully cooperate with the EMMP's efforts to recover benefits it has paid. This includes providing all information requested by the Claims Administrator or its representatives. As part of this process, Aetna may ask you to complete and submit certain applications or other forms or statements. If you fail to provide this information, it will be considered a breach of contract and may result in the termination of your health benefits or the instigation of legal action against you.

You must notify Aetna.

Claims

If a lawsuit or any other claim is filed to recover damages due to injuries sustained by you or a covered family member, you must notify Aetna. This must be done within 30 days of the date the notice of the lawsuit or claim is given to a person, including an attorney.

The Plan is paid first.

The EMMP's subrogation rights are a first priority claim against all potentially responsible person(s), and must be paid before any other claim for damages.

The Plan is entitled to full reimbursement.

The EMMP is entitled to full reimbursement first from any payments made by any responsible person(s). This reimbursement must be made, even if the payment is not enough to compensate you or your covered family member in part or in whole for damages. The terms of this plan provision apply and the EMMP is entitled to full recovery whether or not any liability for payment is admitted by any potentially responsible person(s), and whether or not the settlement or judgment you receive identifies the medical benefits provided by the plan. The EMMP may be reimbursed from **any and all** settlements and judgments, even those for pain and suffering or non-economic damages only.

Aetna chooses the court for any legal action.

Any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction Aetna selects. When you receive benefits under this plan, you agree to this rule and waive whatever rights you have by reason of your present or future place of residence.

The Plan is not responsible for your attorneys' fees.

The EMMP is not required to participate in or pay attorney fees to the attorney you hire to pursue your claim for damages.

Interpreting this provision.

If there is any question about the meaning or intent of this plan provision or any of its terms, the EMMP will have the sole authority and discretion to resolve all disputes as to how this provision will be interpreted.

Claim Procedures

A claim occurs whenever a plan participant requests:

- An authorization or referral from a participating provider or Aetna; or
- Payment for items or services received.

Because you are a participant in an HMO-type plan, you do not need to submit a claim for most of your covered healthcare expenses. However, if you receive a bill for covered services, the bill must be submitted promptly to Aetna for payment. Send the itemized bill for payment with your identification number clearly marked to the address shown on your ID card.

Claims

You must submit a claim form within one calendar year from the date of a service.

Aetna will make a decision on your claim using coverage policies and the definitions found in the "Glossary" of this document. For **concurrent care** claims, Aetna will send you written notification of an affirmative benefit determination. For other types of claims, you may only receive notice if Aetna makes an **adverse benefit determination**.

Adverse benefit determinations are decisions Aetna makes that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

- The individual is not eligible to participate in the Plan; or
- Aetna determines that a benefit or service is not covered by the Plan because:
 - it is not included in the list of covered benefits,
 - it is specifically excluded,
 - a Plan limitation has been reached, or
 - it is not medically necessary.

Aetna will provide you with written notices of adverse benefit determinations within the time frames shown below. These time frames may be extended under certain limited circumstances. The notice you receive from Aetna will provide important information that will assist you in making an appeal of the adverse benefit determination, if you wish to do so. Please see "Complaints and Appeals" for more information about appeals.

Type of Claim	Response Time
Urgent care claim: a claim for medical care or treatment where delay could: <ul style="list-style-type: none"> • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment. 	As soon as possible but not later than 72 hours
Pre-service claim: a claim for a benefit that requires Aetna's approval of the benefit in advance of obtaining medical care.	15 calendar days
Concurrent care claim extension: a request to extend a previously approved course of treatment.	Urgent care claim - as soon as possible, but not later than 24 hours, provided the request was received at least 24 hours prior to the expiration of the approved treatment. Other claims - 15 calendar days
Concurrent care claim reduction or termination: a decision to reduce or terminate a course of treatment that was previously approved.	With enough advance notice to allow the plan participant to appeal.
Post-service claim: a claim for a benefit that is not a pre-service claim.	30 calendar days

Claims

Extensions of Time Frames

The time periods described in the chart may be extended.

For urgent care claims: If Aetna does not have sufficient information to decide the claim, you will be notified as soon as possible (but no more than 24 hours after Aetna receives the claim) that additional information is needed. You will then have at least 48 hours to provide the information. A decision on your claim will be made within 48 hours after the additional information is provided.

For non-urgent pre-service and post service claims: The time frames may be extended for up to 15 additional days for reasons beyond the plan's control. In this case, Aetna will notify you of the extension before the original notification time period has ended. If you fail to provide the information, your claim will be denied.

If an extension is necessary because Aetna needs more information to process your post service claim, Aetna will notify you and give you an additional period of at least 45 days after receiving the notice to provide the information. Aetna will then inform you of the claim decision within 15 days after the additional period has ended (or within 15 days after Aetna receives the information, if earlier). If you fail to provide the information, your claim will be denied.

Grievances and Appeals

There are procedures for you to follow if you are dissatisfied with a decision that Aetna has made or with the operation of the Plan. The process depends on the type of complaint you have. There are two categories of complaints:

- Quality of care or operational issues; and
- Adverse benefit determinations.

Complaints about quality of care or operational issues are called grievances. Complaints about adverse benefit determinations are called appeals.

Grievances

Quality of care or operational issues arise if you are dissatisfied with the service received from Aetna or want to complain about a participating provider. To make a complaint about a quality of care or operational issue (called a grievance), call or write to Member Services within 30 days of the incident. Include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written decision within 30 calendar days of the receipt of the grievance, unless additional information is needed, but cannot be obtained within this time frame. The notice of the decision will specify what you need to do to seek an additional review.

Claims

Appeals of Adverse Benefit Determinations

Aetna will send you written notice of an adverse benefit determination. The notice will give the reason for the decision and will explain what steps you must take if you wish to appeal. The notice will also tell you about your rights to receive additional information that may be relevant to the appeal. Requests for appeal must be made in writing within 180 days from the date of the notice.

The Plan provides for two levels of appeal plus an option to seek External Review of the adverse benefit determination. You must complete the two levels of appeal before bringing a lawsuit. The following chart summarizes some information about how appeals are handled for different types of claims. In certain situations, the time frames shown may be extended.

Type of Claim	Level One Appeal	Level Two Appeal
<p>Urgent care claim: a claim for medical care or treatment where delay could:</p> <ul style="list-style-type: none"> • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment. 	<p>36 hours</p> <p>Review provided by Aetna personnel not involved in making the adverse benefit determination.</p>	<p>36 hours</p> <p>Review provided by Appeals Committee.</p>
<p>Pre-service claim: a claim for a benefit that requires Aetna’s approval of the benefit in advance of obtaining medical care.</p>	<p>15 calendar days</p> <p>Review provided by Aetna personnel not involved in making the adverse benefit determination.</p>	<p>15 calendar days</p> <p>Review provided by Appeals Committee.</p>
<p>Concurrent care claim extension: a request to extend a previously approved course of treatment.</p>	<p>Treated like an urgent care claim or a pre-service claim depending on the circumstances</p>	<p>Treated like an urgent care claim or a pre-service claim depending on the circumstances</p>
<p>Post-service claim: a claim for a benefit that is not a pre-service claim.</p>	<p>30 calendar days</p> <p>Review provided by Aetna personnel not involved in making the adverse benefit determination.</p>	<p>30 calendar days</p> <p>Review provided by Appeals Committee.</p>

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna. However, in case of an urgent care claim or a pre-service claim, a physician familiar with the case may represent you in the appeal.

Depending on the type of appeal, you and/or an authorized representative may attend the Level 2 appeal hearing and question the representative of Aetna and any other witnesses, and present your case. The hearing will be informal. You may bring your physician or other experts to testify. Aetna also has the right to present witnesses.

If the Level One and Level Two appeals uphold the original adverse benefit determination, you may have the right to pursue an External Review of your claim. See “External Review” for more information.

Claims

External Review

You may file a voluntary appeal for external review of any final appeal determination that qualifies.

You must complete the two levels of appeal described above before you can appeal for external review. Subject to verification procedures that may be established, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal. You must request this voluntary level of review within 60 days after you receive the final denial notice.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan it will not be asserted that you have failed to exhaust your administrative remedies because of that choice.

An external review is a review by an independent physician, with appropriate expertise in the area at issue, of claim denials and denials based upon lack of medical necessity, or the experimental or investigational nature of a proposed service or treatment. You may request a review by an external review organization (ERO) if:

- You have received notice of the denial of a claim by Aetna; and
- Your claim was denied because Aetna determined that the care was not medically necessary or was experimental or investigational; and
- The cost of the service or treatment in question for which you are responsible exceeds \$500; and
- You have exhausted the applicable appeal process.

The claim denial letter you receive from Aetna will describe the process to follow if you wish to pursue an external review, and will include a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Aetna within 60 calendar days of the date you received the final claim denial letter. The form must be accompanied by a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent physician with appropriate expertise to perform the review. In rendering a decision, the external reviewer may consider any appropriate credible information submitted by you with the Request for External Review Form, and will follow the applicable plan's contractual documents and plan criteria governing the benefits. You will generally be notified of the decision of the External Review Organization within 30 days of Aetna's receipt of your request form and all necessary information. An expedited review is available if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would jeopardize your health. Expedited reviews are decided within 3-5 calendar days after Aetna receives the request.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Aetna. Aetna is responsible for the cost of sending this information to the External Review Organization.

Claims

Claim Fiduciary

For the purpose of section 503 of Title 1 of the Employee Retirement Income Security Act of 1974, as amended (ERISA), Aetna is a fiduciary with complete authority to review all denied claims for benefits under the Plan. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically necessary. In exercising its fiduciary responsibility, Aetna has discretionary authority to:

- Determine whether, and to what extent, you and your covered dependents are entitled to benefits; and
- Construe any disputed or doubtful terms of the Plan.

Aetna has the right to adopt reasonable policies, procedures, rules and interpretations of the Plan to promote orderly and efficient administration. Aetna may not act arbitrarily and capriciously, which would be an abuse of its discretionary authority.

The EMMP is responsible for making reports and disclosures required by ERISA, including the creation, distribution and final content of:

- Summary plan descriptions;
- Summary of material modifications; and
- Summary annual reports.

Member Services

Member Services Department

Customer service professionals (CSPs) are trained to answer your questions and to assist you in using the Plan properly and efficiently.

Call the Member Services toll-free number on your ID card to:

- Ask questions about benefits, referrals and coverage;
- Change your PCP; or
- Notify Aetna about an emergency.

Please call your PCP's office directly with questions about appointments, hours of service, referrals or medical matters.

Also, you must notify Benefits Administration of changes that might affect your eligibility and enrollment status, such as changes in your name or telephone number.

Internet Access

You can access Aetna on the internet at http://www.aetna.com/members/member_services.html to conduct business with the Member Services department electronically.

When you visit the Member Services site, you can:

- Find answers to common questions;
- Change your PCP;
- Order a new ID card; or
- Contact the Member Services department with questions.

Please be sure to include your ID number and e-mail address.

InteliHealth®

InteliHealth is Aetna's online health information affiliate. It was established in 1996 and is one of the most complete consumer health information networks ever assembled. Through this unique program, plan participants have access, via the Internet, to the wisdom and experience of some of the world's top medical professionals in the field today. Access InteliHealth through the Aetna Internet website home page or directly via www.intelihealth.com.

Member Services

Aetna Navigator™

Aetna Navigator provides a single location for the health and medical issues that matter most to you.

In one easy-to-use website, you can perform a variety of self-service functions and take advantage of a vast amount of health information from IntelliHealth®. Access Aetna Navigator™ through the Aetna Internet website home page or directly via **www.aetn navigator.com**.

When you visit the website, you can see some of Aetna Navigator's distinct features:

- A wealth of health information from IntelliHealth, a premier provider of online consumer-based health, wellness and disease-specific information.
- Online customer service functions that allow you to change your primary care physician or primary care dentist, order ID cards, and send e-mail inquiries to Member Services.
- Interactive "Cool Tools," including a medical dictionary, allergy and asthma quizzes, a pregnancy due-date calculator and a heart and breath odometer. To access "Cool Tools," look under "Health Tools."
- A preventive care planner that includes recommendations for screenings and immunizations.

Plan participants with certain Aetna plans may also create password-protected Web pages that are personalized to their health care interests. They have access to the features listed above as well as other options including:

- A personal "benefits snapshot" and claims summary.
- DocFind-A-Specialist, Aetna's enhanced online provider directory that helps plan participants select a specialist based on personal needs and preferences.
- An online survey that allows you to receive customized information based on your personal health interests.

Rights and Responsibilities

Your Rights and Responsibilities

As a plan participant, you have a right to:

- Get up-to-date information about the doctors and hospitals participating in the Plan.
- Obtain primary and preventive care from the PCP you chose from the Plan's network.
- Change your PCP to another available PCP who participates in the Aetna network.
- Obtain covered care from participating specialists, hospitals and other providers.
- Be referred to participating specialists who are experienced in treating your chronic illness.
- Be told by your doctors how to make appointments and get health care during and after office hours.
- Be told how to get in touch with your PCP or a back-up doctor 24 hours a day, every day.
- Call 911 (or any available area emergency response service) or go to the nearest emergency facility in a situation that might be life-threatening.
- Be treated with respect for your privacy and dignity.
- Have your medical records kept private, except when required by law or contract, or with your approval.
- Help your doctor make decisions about your health care.
- Discuss with your doctor your condition and all care alternatives, including potential risks and benefits, even if a care option is not covered.
- Know that your doctor cannot be penalized for filing a complaint or appeal.
- Know how the Plan decides what services are covered.
- Know how your doctors are compensated for the services they provide. If you would like more information about Aetna's physician compensation arrangements, visit their website at www.aetna.com. Select DocFind from the drop-down menu under Quick Tools, then under "How do I learn more about:" select the type of plan you're enrolled in.
- Get up-to-date information about the services covered by the Plan — for instance, what is and is not covered and any applicable limitations or exclusions.
- Get information about co-payments and fees you must pay.
- Be told how to file a complaint, grievance or appeal with the Plan.
- Receive a prompt reply when you ask the Plan questions or request information.
- Obtain your doctor's help in decisions about the need for services and in the grievance process.
- Suggest changes in the Plan's policies and services.

As a plan participant, you have the responsibility to:

- Choose a PCP from the Plan's network and form an ongoing patient-doctor relationship.
- Help your doctor make decisions about your health care.
- Tell your PCP if you do not understand the treatment you receive and ask if you do not understand how to care for your illness.
- Follow the directions and advice you and your doctors have agreed upon.
- Tell your doctor promptly when you have unexpected problems or symptoms.
- Consult with your PCP for non-emergency referrals to specialist or hospital care.
- See the specialists your PCP refers you to.
- Make sure you have the appropriate authorization for certain services, including inpatient hospitalization and out-of-network treatment.
- Call your PCP before getting care at an emergency facility, unless a delay would be detrimental to your health.
- Understand that participating doctors and other health care providers who care for you are not employees of Aetna and that Aetna does not control them.

Rights and Responsibilities

- Show your ID card to providers before getting care from them.
- Pay the co-payments required by the Plan.
- Call Member Services if you do not understand how to use your benefits.
- Promptly follow the Plan's grievance procedures if you believe you need to submit a grievance.
- Give correct and complete information to doctors and other health care providers who care for you.
- Treat doctors and all providers, their staff, and the staff of the Plan with respect.
- Advise Aetna about other medical coverage you or your family members may have.
- Not be involved in dishonest activity directed to the Plan or any provider.
- Read and understand your Plan and benefits. Know the co-payments and what services are covered and what services are not covered.

Federal Notices

This section describes laws and plan provisions that apply to reproductive and women's health issues.

Coverage for Maternity Hospital Stay

Under federal law, the Plan may not restrict benefits for 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 caesarean 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.

The Women's Health and Cancer Rights Act

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

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

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

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

Administrative and ERISA Required Information

Basic Plan Information

Plan Name

ExxonMobil Medical Plan

Plan Sponsor and Participating Affiliates

The ExxonMobil Medical Plan is sponsored by:

Exxon Mobil Corporation

5959 Las Colinas Blvd.
Irving, Texas 75039-2298

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

Certain employees covered by collective bargaining agreements as well as employees of Station Operators Inc., dba ExxonMobil CORS do not participate in the plan.

Plan Numbers

The ExxonMobil Medical Plan is identified with government agencies under two numbers:

The Employer Identification Number (EIN), 13-5409005, and the Plan Number (PN), 538.

Plan Administrators

Various aspects of the Plan are administered by various parties. The Administrator of the Plan shall have the full power to control and manage all aspects of the Plan in accordance with its terms and all applicable laws. The Administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or give advice with respect to its responsibilities under the Plan, including administrative services of the following nature: Claim Administration; Cost Containment; Financial; Banking and Billing Administration. Benefits provided under this plan are funded by ExxonMobil.

The Administrator-Benefits is the Manager-Global Benefits Design, Exxon Mobil Corporation. You may contact the Administrator-Benefits as follows:

Administrator-Benefits

For appeals of eligibility or enrollment issues:

P.O. Box 2283
Houston, Texas 77252-2283

Administrator-Finance

Exxon Mobil Corporation
5959 Las Colinas Blvd.
Irving, Texas 75039-2298

For service of legal process:

4550 Dacoma
Houston, Texas 77092

Administrative and ERISA Required Information

Type of Plan

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

Plan Year

The Plan's fiscal year ends on December 31.

Collective Bargaining Agreements

The Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request. Eligibility for participation in the ExxonMobil Medical Plan by represented employees is governed by local bargaining requirements.

Funding

The Plan is funded through contributions by the Employer and/or plan participants. Benefits under the EMMP are funded through participant and company contributions. Each year, Exxon Mobil Corporation determines the rates of required participant contributions to the Exxon Mobil Medical Plan. These rates are based on past and projected plan experience. This plan is self-funded by ExxonMobil. (See "Self-funded HMO" in the "Glossary".)

Claims Processor

Aetna Life Insurance Company is the claims processor and claims fiduciary.

No Implied Promises

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

If the ExxonMobil Medical Plan is Amended or Terminated

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

Administrative and ERISA Required Information

Your Rights under ERISA

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

Receive Information about Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Administrative and ERISA Required Information

Assistance with Your Questions

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

Glossary

Annual Out-of-Pocket Limit - Expenses you pay for medical services apply towards the annual out-of-pocket maximum including both outpatient and inpatient mental health and substance abuse treatment.

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

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

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

Phone Numbers:	Address:
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • Retirees and Survivors, call: ExxonMobil Benefits Service Center Monday - Friday 8:00 a.m. to 6:00 p.m. (U.S. Eastern Time), except certain holidays Toll-Free: 1-800-682-2847 or 800-TDD-TDD4 (833-8334) for hearing impaired 	ExxonMobil Benefits Service Center P.O. Box 1014 Totowa, NJ 07512-1014
<ul style="list-style-type: none"> • Former Exxon or ExxonMobil Employees, Exxon or ExxonMobil Retirees, or their Survivors or their Dependents, who elected and are participating through COBRA, call: ExxonMobil COBRA Administration Monday - Friday 8:00 a.m. to 8:00 p.m. (U.S. Central Time), except certain holidays Phone: (800) 522-6621 Fax: (770) 619-7160 	ADP Benefit Services ADP National Accounts ExxonMobil COBRA Administration P.O. Box 2968 Alpharetta, GA 30023-2968

Glossary

Benefits Administration / 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 from home by everyone at www.exxonmobilfamily.com.
- Retiree Online Community Internet Site — Can be accessed from home by retirees and survivors only at www.emretiree.com.
- ExxonMobil Benefits Service Center at ACS Internet Site — Can be accessed from home by everyone at www.exxonmobil.com/benefits.

Co-payment (co-pay) - means the fee that must be paid by a plan participant to a participating provider at the time of service for certain covered expenses and benefits, as described in the “Co-payment Schedule.”

Cosmetic surgery - means any surgery or procedure that is not medically necessary and whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not:

- Restore bodily function;
- Correct a diseased state, physical appearance or disfigurement caused by an accident or birth defect; or
- Correct or naturally improve a physiological function.

Covered services and supplies (covered expenses) - means the types of medically necessary services and supplies described in “Your Benefits.”

Custodial care - means any service or supply, including room and board, which:

- Is furnished mainly to help you meet your routine daily needs; or
- Can be furnished by someone who has no professional health care training or skills; or
- Is at a level such that you have reached the maximum level of physical or mental function and are not likely to make further significant progress.

Dependent child - An unmarried person under age 25 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 if the child is residing with the regular employee or retiree. For this purpose, a child is considered to be residing with a regular employee or retiree if the child's permanent residence is considered to be the residence of the regular employee or retiree. Child does not include a foster child.

Glossary

Detoxification - means the process whereby an alcohol-intoxicated, alcohol-dependent or drug-dependent person is assisted in a facility licensed by the state in which it operates, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factor, or alcohol in combination with drugs as determined by a licensed physician, while keeping physiological risk to the patient at a minimum.

Durable medical equipment (DME) - means equipment determined to be:

- Designed and able to withstand repeated use;
- Made for and used primarily in the treatment of a disease or injury;
- Generally not useful in the absence of an illness or injury;
- Suitable for use while not confined in a hospital;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Eligible Dependents - Family members eligible for coverage are your dependents, including:

- Spouse.
- A dependent child who is described in any one of the following paragraphs (1) through (3):
 - (1) is unmarried,
 - (2) is not employed on a regular and full time basis, and
 - (3) is described in any one of the paragraphs (a) through (c) below:
 - (a) has not reached the end of the month during which age 25 is attained, provided the child is chiefly dependent upon the regular employee or retiree for support and maintenance; or
 - (b) is totally and continuously disabled and incapable of self-sustaining employment by reason of mental or, physical disability, provided the child:
 - (i) meets the Internal Revenue Service's definition of a dependent and
 - (ii) either
 - (A) was, or would have been, covered as an eligible dependent under this Plan immediately prior to the birthday on which the child's eligibility would have otherwise ceased, or
 - (B) was covered as an eligible dependent 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
 - (iii) the child is disabled before such birthday and has remained continuously disabled, and
 - (c) 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

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requirements of paragraph 3(b)(i) above, ceases to be an eligible dependent 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.

Eligible employees - Most U.S. dollar-paid employees of Exxon Mobil Corporation and participating affiliates are eligible. Full-time employees not hired on a temporary basis (also 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: employees of Station Operators, Inc. (SOI), 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.

Emergency - means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.
- With respect to emergency services furnished in a hospital emergency department, the Plan does not require prior authorization for such services if you arrive at the emergency medical department with symptoms that reasonably suggest an emergency condition, based on the judgment of a prudent layperson, regardless of whether the hospital is a participating provider. All medically necessary procedures performed during the evaluation (triage and treatment of an emergency medical condition) are covered by the Plan.

Expatriate Employees- means 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 - means services or supplies that are determined by Aetna to be experimental. A drug, device, procedure or treatment will be determined to be experimental if:

- There are not sufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- Required FDA approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or

Glossary

- The written protocol(s) used by the treating facility or the protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
- It is not of proven benefit for the specific diagnosis or treatment of your particular condition; or
- It is not generally recognized by the medical community as effective or appropriate for the specific diagnosis or treatment of your particular condition; or
- It is provided or performed in special settings for research purposes.

ExxonMobil Medical Plan - The plan sponsored by Exxon Mobil Corporation which provides medical benefits for eligible employees, retirees, survivors and their dependents and includes the HMO option and POS II option.

Home health services - means those items and services provided by participating providers as an alternative to hospitalization, and approved and coordinated in advance by Aetna.

Hospice care - means a program of care that is:

- Provided by a hospital, skilled nursing facility, hospice or duly licensed hospice care agency;
- Approved by Aetna; and
- Focused on palliative rather than curative treatment for a plan participant who has a medical condition and a prognosis of less than 6 months to live.

Hospital - means an institution rendering inpatient and outpatient services, accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by Aetna as meeting reasonable standards. A hospital may be a general, acute care, rehabilitation or specialty institution.

Infertility - means:

- For a female who is under age 35, the inability to conceive after one year or more without contraception or 12 cycles of artificial insemination.
- For a female who is age 35 or older, the inability to conceive after six months without contraception or six cycles of artificial insemination.

Medical services - means those professional services of physicians or other health professionals, including medical, surgical, diagnostic, therapeutic and preventive services authorized by Aetna.

Medically necessary - means services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards, as described in the “Your Benefits” section of this booklet. To be medically necessary, the service or supply must:

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well-baby care, as determined by Aetna;
- Be a diagnostic procedure, indicated by the health status of the plan participant, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;

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- Include only those services and supplies that cannot be safely and satisfactorily provided at home, in a physician's office, on an outpatient basis, or in any facility other than a hospital, when used in relation to inpatient hospital services; and
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining whether a service or supply is medically necessary, Aetna will consider:

- Information provided on your health status;
- Applicable standard of care;
- Aetna's Clinical Policy Bulletin's and other non-case specific materials, which shall be based on medical and Scientific Evidence;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved;
- The opinion of the attending physicians, which has credence but does not overrule contrary opinions; and
- Any other relevant information brought to Aetna's attention

In no event will the following services or supplies be considered medically necessary:

- Services or supplies that do not require the technical skills of a medical, mental health or dental professional;
- Custodial care, supportive care or rest cures;
- Services or supplies furnished mainly for the personal comfort or convenience of the patient, any person caring for the patient, any person who is part of the patient's family or any health care provider;
- Services or supplies furnished solely because the plan participant is an inpatient on any day when their disease or injury could be diagnosed or treated safely and adequately on an outpatient basis;
- Services furnished solely because of the setting if the service or supply could be furnished safely and adequately in a physician's or dentist's office or other less costly setting; or
- Experimental services and supplies, as determined by Aetna.

Mental or nervous condition - means a condition which manifests signs and/or symptoms that are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication. Mental or behavioral disorders and conditions include, but are not limited to:

- Psychosis;
- Affective disorders;
- Anxiety disorders;
- Personality disorders;
- Obsessive-compulsive disorders;
- Attention disorders with or without hyperactivity; and
- Other psychological, emotional, nervous, behavioral or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition.

Outpatient - means:

- A plan participant who is registered at a practitioner's office or recognized health care facility, but not as an inpatient; or

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- Services and supplies provided in such a setting.

Participating provider - means a provider that has entered into a contractual agreement with Aetna to provide services to plan participants.

Physician - means 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.

Plan benefits - means the medical services, hospital services, and other services and care to which a plan participant is entitled, as described in this booklet.

Plan participant - means an employee or covered dependent.

Primary Care Physician (PCP) - means a participating physician who supervises, coordinates, and provides initial care and basic medical services as a general or family care practitioner or, in some cases, as an internist or a pediatrician, to Plan participants; initiates their referral for specialist care; and maintains continuity of patient care.

Provider - means a physician, health professional, hospital, skilled nursing facility, home health agency, or other recognized entity or person licensed to provide hospital or medical services to Plan participants.

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

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

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

Referral - means specific written or electronic direction or instruction from a Plan participant's PCP, in conformance with Aetna's policies and procedures, which directs the Plan participant to a participating provider for medically necessary care.

Retiree - Generally, a person at least 55 years old who retires with 15 or more years of benefit plan service. 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 plan service, regardless of age.

Self-funded HMO (As used in the ExxonMobil Medical Plan as self-insured HMO.) - A self-funded HMO, under the EMMP, is an option set up by ExxonMobil to set aside funds to pay employees' health claims. Because ExxonMobil has hired insurance companies to administer the claims for these plans, they may look just like fully insured plans but they are funded by ExxonMobil. For example, all Aetna HMO options under the

Glossary

EMMP are self-insured HMOs. Aetna is responsible for processing claims and is the claims fiduciary. (i.e., Aetna makes the final decision on claims under those plans.) ExxonMobil is responsible for providing the funds to the Plan to pay health claims. This does not impact the way that your HMO operates. The U.S. Department of Labor regulates self-funded plans, not the state. You may contact the Department of Labor at the address listed in the ERISA section: Assistance With Your Questions.

Service area - means the geographic area, established by Aetna and approved by the appropriate regulatory authority, in which a Plan participant must live or otherwise meet the eligibility requirements in order to be eligible as a participant in the Plan. This area is determined by the participant's home address zip code.

Skilled nursing facility - means an institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a skilled nursing facility, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by Aetna to meet the reasonable standards applied by any of the aforesaid authorities.

Specialist - means a physician who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

Substance abuse - means any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

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. A person remains a suspended retiree until the earlier of the date the person:

- Reaches age 55, or
- Begins his or her benefit or receives a lump-sum settlement 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.

Terminal illness - means an illness of a Plan participant, which has been diagnosed by a physician and for which they have a prognosis of six (6) months or less to live.

Urgent medical condition - means a medical condition for which care is medically necessary and immediately required because of unforeseen illness, injury or condition, and it is not reasonable, given the circumstances, to delay care in order to obtain the services through your home service area or from your PCP.

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

In determining your specific benefits, the full provisions of the formal plan documents, as they exist now or as they may exist in the future, govern. Part 4 of the EMMP formal plan document is intended as the sole document that sets out the benefits provided through the Aetna self-funded HMO option (Aetna HMO). You may obtain copies of these documents by making a written request to the Administrator-Benefits. ExxonMobil reserves the right at any time to change in any way or terminate any benefit.

This booklet covers the major features of the EMMP Aetna HMO administered by Aetna Life Insurance Company, effective January 1, 2010. The plan description has been designed to provide a clear and understandable summary of the Plan, and with the Provider directory serves as the Summary Plan Description (SPD) required for plans subject to ERISA.

The EMMP Aetna HMO option administered by Aetna Life Insurance Company is self-funded. 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. This option is governed by federal laws, not state insurance laws.

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

Aetna HMO
Revised 01/2010

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