ExxonMobil Health and Welfare Plan
2025 Wrap Summary Plan Description

ExxonMobil

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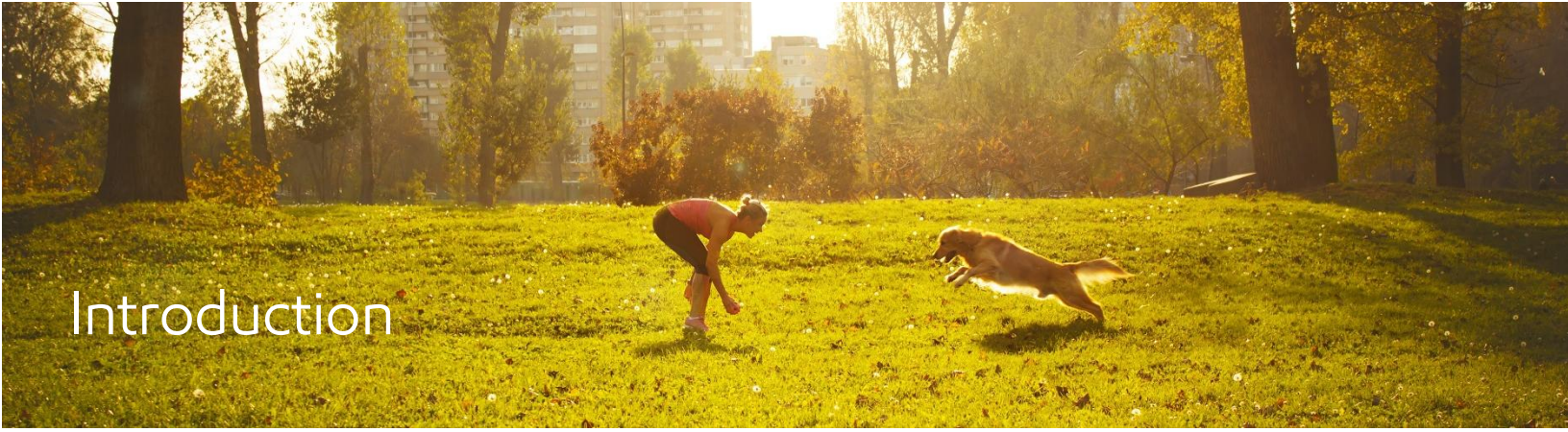


Introduction

Overview

The ExxonMobil Health and Welfare Plan (the "Plan") is an employer-sponsored health and welfare employee benefit plan of Exxon Mobil Corporation (the "Corporation"). A detailed list of the Welfare Programs provided under the Plan, along with contact information and more information about how to access Welfare Program Documents describing these benefits, can be found in the Welfare Programs and Eligibility section of this Summary Plan Description ("SPD"). Unless otherwise noted, the Welfare Programs under the Plan are governed under ERISA.

The terms and conditions of the Plan are set forth in this SPD, the Plan Document, and Welfare Program Documents. Together, these documents are incorporated by reference into the Plan Document and constitute the written instruments under with the Plan is established and maintained. An amendment to one of these documents constitutes an amendment to the Plan.

This Summary Plan Description should be read in connection with any applicable Welfare Program provided by the Insurers or Claims Administrators listed in the Welfare Programs and Eligibility section. Unless otherwise noted, if there is a conflict between a specific provision under the Plan Document and a Welfare Program or this SPD, the Plan Document controls. If the Plan Document is silent on a specific issue, then the SPD controls on that issue, except where the SPD refers to a Welfare Program, in which case the Welfare Program controls. If both the Plan Document and SPD are silent, the terms of the applicable Welfare Program controls.

With respect to fully insured benefits, the terms of the applicable Welfare Program Documents control when describing specific benefits that are covered or insurance-related terms. Nothing in this document or any of the Welfare Program Documents shall be construed as to change the funding nature of any Welfare Program, such as transferring a fully insured Welfare Program into a self-funded Welfare Program, or vice versa. For example, the use of fully insured language and terminology in a self-funded Welfare Program would not change the funding structure of that Welfare Program. See the Welfare Programs and Eligibility section of this SPD to determine if a particular Welfare Program is self-funded by the Corporation or fully insured by the Insurer.

Exxon Mobil Corporation reserves the right to change, amend, suspend, or terminate any or all of the benefits under this Plan, in whole or in part, at any time for any reason at its sole discretion.

Plan Contact Information

Questions concerning this Plan can be directed to the Administrator-Benefits listed in the Administrative Information section or the applicable Insurer or Claims Administrator listed in the Welfare Programs and Eligibility section.

Administrative Information

Plan Name & Number	ExxonMobil Health and Welfare Plan (640)
Plan Sponsor	Exxon Mobil Corporation 22777 Springwoods Village Parkway Spring TX 77389
Employer Identification Number	13-5409005
Plan Administrator	The Plan Administrator for the Plan is the Administrator-Benefits. The Administrator-Benefits is the Global Benefits and Programs Design Manager, Human Resources Department of Exxon Mobil Corporation.
Agent for Service of Legal Process	Corporation Service Co. 211 East 7th Street, Suite 620 Austin, Texas 78701-3218
Plan Year	Calendar Year (January 1 – December 31)
Plan Type	Health and welfare benefits, including medical, dental, vision, disability, life, employee assistance program ("EAP"), wellness, and on-site clinic services
Administration & Funding	Self-funded benefits are administered by the Claims Administrators listed in the Welfare Programs and Eligibility section of this SPD. The Plan Sponsor is responsible for paying claims with respect to the self -funded benefits; claims are paid from the Corporation's general assets. Insured benefits are administered by the Insurers listed in the Welfare Programs and Eligibility section. Fully insured benefits will be paid out of the insurance policies listed in that section.
Source of Contributions	Contributions will be paid out of the Corporation's general assets and through contributions paid by Eligible Employees and Retirees, in the amounts determined by the Corporation in its discretion.

Glossary

Administrator-Benefits: As defined in ERISA section 3(16), Plan Administrator means the individual holding the position of Global Benefits and Programs Design Manager, Human Resources Department of Exxon Mobil Corporation, or if no such position exists, the individual from time to time performing such function.

Annual Enrollment Period: The annual enrollment period designated by the Administrator-Benefits.

Child: A person under age 26 who is:

- A natural or legally adopted child of an Eligible Employee;
- A grandchild, niece, nephew, cousin, or other child related by blood or Marriage to an Eligible Employee, or cases where the Spouse of an Eligible Employee (separately or together) is the sole court appointed legal guardian or sole managing conservator;
- A child for whom the Eligible Employee has assumed a legal obligation for support immediately prior to the child's adoption by an Eligible Employee; or
- A stepchild of an Eligible Employee.

Child does not include a foster child

Claims Administrator: A third party that makes claims determinations under the Plan pursuant to a contractual arrangement with the Corporation. Claims Administrators process your claims with respect to the benefits that are self-funded by the Corporation. These third-party administrators ("TPAs") do not insure any benefits under the Plan. The Welfare Programs and Eligibility section of the SPD lists the Claims Administrators and identifies benefits that are self-funded by the Corporation.

Claims Fiduciary: For the purpose of ERISA section 503, the Claims Fiduciary is the person with complete authority to review all denied claims for benefits under the Plan. Each Claims Fiduciary has the right to adopt reasonable policies, procedures, rules and interpretations of the Plan to promote orderly and efficient administration. A Claims Fiduciary may not act arbitrarily and capriciously, which would be an abuse of its discretionary authority.

The Consolidated Omnibus Budget Reconciliation Act ("COBRA"): The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code: Internal Revenue Code of 1986, as amended from time to time.

Corporation: Exxon Mobil Corporation and any successor that shall maintain this Plan.

Covered Person: Any person identified on the books of the Corporation or Participating Employer as an Eligible Employee, Extended Part-Time Employee, Eligible Family Member, or Survivor who:

- Complies with the established enrollment requirements and makes any required contributions; and

- Is not eligible for any other medical plan to which ExxonMobil contributes on their behalf.

Eligible Employee: An Eligible Employee with respect to the Plan is generally a U.S. dollar payroll employee who is employed by the Corporation or a Participating Employer and is eligible to participate in and receive benefits under one or more of the Welfare Programs. Typically, temporary, part-time, seasonal or leased employees, independent contractors (including individuals employed under a contract that specifically excludes their eligibility for benefits) are not eligible, but the specific eligibility and participation requirements may vary depending on the Welfare Program. You must satisfy the eligibility requirements under a particular Welfare Program to receive benefits under that program.

Eligible Family Members: Eligible family members are generally your:

- Spouse
- A Child who is described in any one of the following paragraphs (1) through (3):
    1. has not reached the end of the month during which age 26 is attained; or
    2. is totally and continuously disabled and incapable of self-sustaining employment by reason of mental or physical disability, provided the Child:
        - meets the Internal Revenue Service's definition of a dependent, and
        - was covered as an Eligible Family Member under this Plan immediately prior to age 26 when the Child's eligibility would have otherwise ceased, and
        - met the clinical definition of totally and continuously disabled before age 26 and continues to meet the clinical definition through subsequent periodic reassessment reviews; or
    3. is recognized under a QMCSO as having a right to coverage under this Plan.

A Child aged 26 or over who was disabled but who no longer meets the requirements of paragraphs two (2) above, ceases to be an Eligible Family Member 60 days following the date on which the applicable requirement is not met.

Please note: An Eligible Employee's parents are not eligible to be covered.

Employers: The Corporation and all Participating Employers (as listed at Appendix A).

The Employee Retirement Income Security Act ("ERISA"): The Employee Retirement Income Security Act of 1974, as amended from time to time.

Expatriate or Expatriate Employee: Expatriate employee of a Participating Employer include Regular Employees working on an assignment outside the United States where the terms of the assignment require proof of adequate medical coverage.

Extended Part-Time Employee: Employee who is classified as non-regular employee, but who has been designated as an Extended-Part Time Employee under their employer´s employment policies relating to flexible work arrangements. Effective January 1, 2023, no new employees meeting the definition of Extended Part-time will be eligible to participate in the plan, as this classification no longer exists.

Employee: Employee who has been approved to continue work on a non-regular part-time arrangement beyond the initial two years as a part-time regular employee.

ExxonMobil Retiree Medical Plan: The ExxonMobil Retiree Medical Plan ("EMRMP"). Pre-Medicare eligible Retirees, Survivors and their Eligible Family Members participating in the EMRMP are also eligible for certain benefits under the Plan as described in the Welfare Programs and Eligibility section of this SPD.

Health Insurance Portability and Accountability Act ("HIPAA"): The Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Insurer: The insurance companies listed in the Welfare Programs and Eligibility section of this SPD that the Corporation has contracted with to provide insurance coverage. Insurers process your claims with respect to the Plan's fully insured medical benefits. These benefits are paid by the Insurer under the terms of the Insurance Policy.

Internal Revenue Code ("Code"): The Internal Revenue Code of 1986, as amended from time to time.

Non-Regular or Non-Regular Employee: Temporary or part-time employee of a Participating Employer who otherwise would be a covered employee but for the fact, as determined by the Participating Employer, that the person either does not regularly work a full-time schedule or is employed on a temporary basis. Non-Regular Employees include Extended Part-Time (enhanced Non-Regular) Employees.

Participating Employer: The Corporation and any other entity that adopts the Plan with the consent of the Corporation and as listed at Appendix A.

Plan: ExxonMobil Health and Welfare Plan.

Plan Document: The formal wrap plan document that, along with this SPD, and the Welfare Program Documents, constitute the Plan Document for purposes of ERISA.

Plan Sponsor: Exxon Mobil Corporation.

Plan Year: The calendar year (January 1 – December 31).

Qualified Medical Child Support Order ("QMCSO"): A QMCSO is a court decree under which a court order mandates health coverage for a Child. The Plan will extend medical benefits to an Eligible Employee's non-custodial Child as required by any QMCSO under ERISA §609(a), including a National Medical Support Notice. A QMCSO must include, at a minimum:

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

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

Regular or Regular Employee: A U.S. dollar payroll employee of a Participating Employer, who, as determined by the Participating Employer, regularly works a full-time schedule, and is not employed on a temporary or part-time basis. The definition includes a person who regularly works a full-time schedule but who, for a limited period of time, is approved for a part-time regular work arrangement under the Participating Employer's work rules relating to part-time work for Regular Employees.

Retiree: Generally, a person at least 55 years-old who retires as a Regular Employee with 15 or more years of benefit service, as defined under the ExxonMobil Benefit Plans Common Provisions, or someone who is retired by the Corporation and entitled to long-term disability benefits under the ExxonMobil Disability Welfare Program after 15 or more years of benefit service, regardless of age.

Retirees are generally eligible for the following Plan Welfare Programs:

- Dental
- Vision
- Long Term Disability, a component of the Disability Welfare Program
- Certain components of the Life Insurance Welfare Program

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

Summary Plan Description ("SPD"): This document, which describes terms that apply to the benefits under the Plan and, when combined with the Welfare Program Documents, constitute the SPD that is required under ERISA.

Survivor/Surviving Spouse: A Surviving unmarried Spouse or Child of a deceased ExxonMobil Regular Employee or Retiree.

Suspended Retiree: A person who becomes a Retiree due to incapacity (and not age) within the meaning of the ExxonMobil Disability Welfare Program and who begins long term disability benefits under that Program, 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 the benefit under the ExxonMobil Pension Plan, at which time, the person is again considered a Retiree.

Additional information regarding Suspended Retirees can be found in the EMRMP and Disability Welfare Program Booklet.

Trainee: An employee who is classified as a Non-Regular Employee, but who has been characterized as a Trainee and has graduated from high school. This definition does not apply to individuals not on the U.S. payroll who are in the U.S. on a Trainee assignment and are not on an Expatriate assignment into the U.S.

Welfare Program: An employee welfare benefit offered as part of the Plan, as described in the Welfare Programs and Eligibility section of this SPD.

Welfare Program Documents: All provisions of any document for the Plan that set forth terms and conditions of the Welfare Programs, including without limitation (i) this SPD; (ii) any and all insurance policies, contracts, certificates of insurance and other documents that set forth the terms and conditions of an insured Welfare Program; and (iii) any and all benefits books or other formal documents provided by TPAs of any self-insured Welfare Programs. Any amendment to a Welfare Program Document will constitute automatically an amendment to the Plan.

Welfare Programs Eligibility

The purpose of the Plan is to provide participants and beneficiaries with certain welfare benefits described herein. The following Welfare Programs are available under the Plan:

Health Benefits

Medical, Behavioral Health and Prescription Drug Benefits

Self-Funded; Covered by ERISA.

Eligibility

- Regular Employees,
- Individuals rehired as Regular or Non-Regular Employees after attaining Retiree status;
- Trainees,
- Extended Part-Time Employees enrolled in the Plan on December 31, 2022, who continue to participate in the Plan,
- Survivor/Surviving Spouse (an Eligible Family Member of a deceased Regular Employee),
- Individuals entitled to COBRA continuation coverage under the Plan as a result of the Plan becoming a "successor plan" as required by applicable law, as determined by the Administrator-Benefits, and
- Eligible Family members.

Claims Administrator – Medical and Behavioral Health Benefits

BlueCross BlueShield of Texas

Blue Cross Blue Shield of Texas ("BCBSTX")

P.O. Box 660044 - Dallas, Texas 75266-0044
Phone number: 877-278-5214
Group Number: 388933

For additional details, see Appendix B and bcbstx.com/exxonmobil (goto/bcbs from a device issued by the Corporation).

Programs under your Health Benefits

Virtual Care Program

Self-funded; Covered by ERISA.

Claims Administrator

MDLIVE

MDLive

888 409 8687
Group Number: 1139

Second Opinion Services

Self-funded; Covered by ERISA.

Claims Administrator

alight

My Medical Ally

888-361-3944
Company name: ExxonMobil

For additional details, see MyMedicalAlly.alight.com (Corporation name: ExxonMobil)

Fertility Program

Self-funded; Covered by ERISA.

Eligibility

- Regular Employees,
- Individuals rehired as Regular or Non-Regular Employees after attaining Retiree status,
- Trainees,
- Extended Part-Time Employees enrolled in the Plan on December 31, 2022 who continue to participate in the Plan,
- Individuals entitled to COBRA continuation coverage under the Plan as a result of the Plan becoming a "successor plan" as required by applicable law, as determined by the Administrator-Benefits, and
- Eligible Family Members (Spouses only, Children are not eligible)

Claims Administrator

progyny
Smarter Fertility Benefits

Progyny

833-851-2229

For additional details, see progyny.com.

Onsite Clinic

Self-Funded; Covered by ERISA.

Eligibility

- Regular Employees,
- Individuals rehired as Regular or Non-Regular Employees after attaining Retiree status,
- Extended Part-Time Employees enrolled in the Plan on December 31, 2022, who continue to participate in the Plan,
- Trainees,
- Individuals entitled to COBRA continuation coverage under the Plan as a result of the Plan becoming a "successor plan" as required by applicable law, as determined by the Administrator-Benefits, and
- Eligible Family Members.

Claims Administrator

WeCare tlc, LLC

Midland Clinic:

4815 East Highway 80
Midland, TX 79706
Phone: 432-571-2680

Claims Administrator – Prescription Drug Benefits

EXPRESS SCRIPTS®

Express Scripts

Customer service: 800-695-4116
Accredo Specialty: 800-803-2523

If you need to submit a direct reimbursement claim form:

- Fax: 608 741-5475
- Mail: Express Scripts, ATTN: Commercial Claims - P.O. Box 14711 - Lexington, KY 40512-4711

For additional details, see Appendix B and Express-scripts.com or Accredo.com.

Express Scripts Partnership Programs

Musculoskeletal ("MSK") Program

Self-funded; Covered by ERISA.

Administrator

Hinge Health

hello@hingehealth.com
855 902 2777
Group Number: 1139

For additional details, see **hingehealth.com/for/exxonmobil**.

Weight Management/Prevention, Diabetes Management and Hypertension Management Programs

Self-funded; Covered by ERISA.

Administrator

Omada Health

888-987-8337

For additional details, see omadahealth.com/exxonmobil.

Employee Assistance Program

Self-Funded; Covered by ERISA.

Eligibility

- All U.S. Employees, and
- Eligible Family Members.

Claims Administrator

ComPsych

455 North Cityfront Plaza Drive
Chicago, IL 60611
Group ID: ExxonMobil

For additional details, see Appendix B and https://www.guidanceresources.com/

Mobile App: GuidanceNow

Dental

Self-Funded; Covered by ERISA.

Eligibility

- Regular Employees,
- Individuals rehired as Regular or Non-Regular Employees after attaining Retiree status,
- Trainees,
- Extended Part-Time Employees enrolled in the Plan on December 31, 2022 who continue to participate in the Plan,
- U.S. Pre-65 and Post-65 Retirees,
- Survivor/Surviving Spouse (an Eligible Family Member of a deceased Regular Employee or Retiree),
- Long-term Expatriate with U.S. Corporation-sponsored green card (also called permanent resident visas or PRVs) who retires/retired at the end of a current U.S. assignment on or after July 1, 2020 and remains in the U.S. with a valid PRV. The only opportunity to enroll will be upon retirement. There will be no opportunity to enroll after retirement,
- Individuals entitled to COBRA continuation coverage under the Plan as a result of the Plan becoming a "successor plan" as required by applicable law, as determined by the Administrator-Benefits, and
- Eligible Family Members.

Claims Administrator

Delta Dental Insurance Company

P.O. Box 1809, Alpharetta, GA 30023
833-459-1169
Group Number: 22860

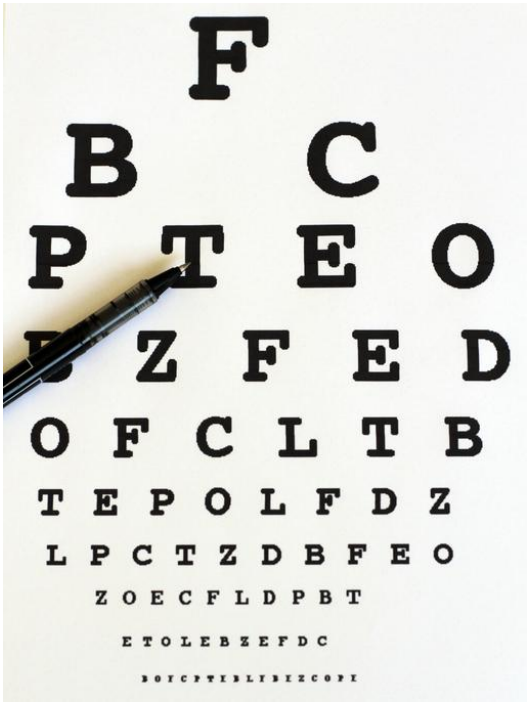
For additional details, see Appendix B and www1.deltadentalins.com/ exxonmobil (goto/deltadental from a device issued by the Corporation)

Vision

Fully insured; Covered by ERISA.

Eligibility

- Regular Employees,
- Individuals rehired as Regular or Non-Regular Employees after attaining Retiree status,
- Trainees,
- Extended Part-Time Employees enrolled in the Plan on December 31, 2022 who continue to participate in the Plan,
- U.S. Pre-65 and Post-65 Retirees,
- Survivor/Surviving Spouse (an Eligible Family Member of a deceased Regular Employee or Retiree),
- Long-term Expatriate with U.S. Corporation-sponsored green card (also called permanent resident visas or PRVs) who retires/retired at the end of a current U.S. assignment on or after July 1, 2020 and remains in the U.S. with a valid PRV. The only opportunity to enroll will be upon retirement. There will be no opportunity to enroll after retirement,
- Individuals entitled to COBRA continuation coverage under the Plan as a result of the Plan becoming a "successor plan" as required by applicable law, as determined by the Administrator-Benefits, and
- Eligible Family Members.



Insurer

MetLife | Vision Insurance

Metropolitan Life Insurance Company

700 Quaker Lane
2nd Floor
Warwick, RI 02886
1-833-EYE-LIFE
Policy Number: 191000-1-G

For additional details, see Appendix B and metlife.com/info/exxonmobil (goto/metlifevision from a device issued by the Corporation)

Health Care Flexible Spending Account ("HCFSA")

Self-Funded; Covered by ERISA.

Eligibility

- Regular Employees, excluding Wolverine Pipeline Company employees,
- Extended Part-Time Employees enrolled in the Plan on December 31, 2022 who continue to participate in the Plan,
- Expatriate Employees who are participating in the ExxonMobil International Medical and Dental Plan.

FSA Administrator – Claims and Administrative Appeals

MetLife

PO box 2724
Fargo, ND 58108-2724
833-675-2831

Administrator – Benefits – Eligibility Appeals
ExxonMobil Health and Welfare Plan
DEPT 02694 - PO Box 64116
The Woodlands, TX, 77387-4116

For additional details, see Appendix B and healthsavingsandspending.metlife.com (goto/metlifefsa)

Dependent Care Flexible Spending Account ("DCFSA")

Self-Funded; Not Covered by ERISA.

Eligibility

- Regular Employees, excluding Wolverine Pipeline Company employees,
- Extended Part-Time Employees enrolled in the Plan on December 31, 2022 who continue to participate in the Plan, and
- Expatriate Employees who are participating in the ExxonMobil International Medical and Dental Plan.

FSA Administrator – Claims and Administrative Appeals

MetLife

PO box 2724
Fargo, ND 58108-2724
833-675-2831

Administrator – Benefits – Eligibility Appeals
ExxonMobil Health and Welfare Plan
DEPT 02694 - PO Box 64116
The Woodlands, TX, 77387-4116

For additional details, see Appendix B and https://healthsavingsandspending.metlife.com/

Disability Benefits

Short-term Disability ("STD")

As determined by state law, funded either with employee contributions, Employer contributions or a combination of both employee and Employer contributions. Where mandated by state law requirements, STD benefits will be funded either with employee contributions, Employer contributions or a combination of both employee and Employer contributions. Where no state law mandate applies, benefits are self-funded and covered by ERISA.

Eligibility

- Regular Employees, and
- Extended Part-Time Employees enrolled in the Plan on December 31, 2022, who continue to participate in the Plan, and
- Expatriate Employees.

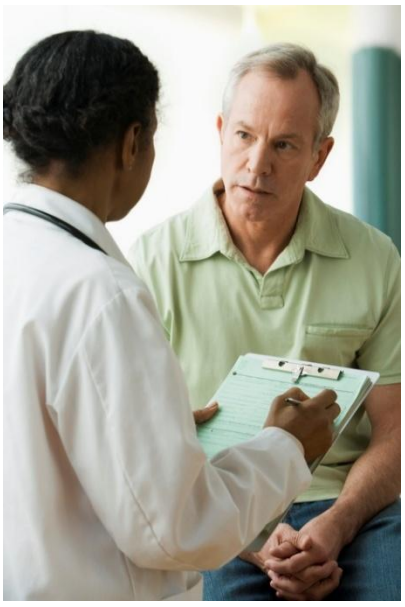
Administrator - Benefits:

DEPT 02694
PO Box 64116
The Woodlands, TX, 77387-4116
833-776-9966

Employees may also be covered by state mandated disability benefits. For additional details, see Appendix B.

Long-term Disability ("LTD")

Self-Funded; Covered by ERISA



Eligibility

- Regular Employees with more than one year of benefit service,
- Extended Part-Time Employees enrolled in the Plan on December 31, 2022 who continue to participate in the Plan, and
- Expatriate Employees.

Claims Administrator

Alight

alight

PO Box 1438
Lincolnshire, IL 60069
855-250-4170

For additional details, see Appendix B.

Life and Accidental Death & Dismemberment ("AD&D") Insurance

Basic Life Insurance

Self-Funded; Covered by ERISA.

Eligibility

- Regular Employees,
- Expatriate employees,
- Extended Part-Time Employees enrolled in the Plan on December 31, 2022, who continue to participate in the Plan, and
- Certain Retirees as described below:
    - Anyone who becomes a **Retiree** after January 1, 2000 and before December 2, 2015, and
    - An Eligible Employee participating in the plan as of December 1, 2015, who is at least 50 years of age with at least 10 years of benefit service and becomes a Retiree after December 1, 2015.

Employees participating in the Exxon Family Adjustment and Family Income Plan or participating in the Executive Life Insurance/Death Benefit Plan are not eligible for Basic Life Coverage.

Insurer

Connecticut General Life Insurance Company (CGLIC)

800-238-2125 (toll free)
412-402-3000 (international)

Cigna Secure Travel

Although not a Benefit provided under the Plan, Cigna offers Emergency Travel Assistance Services. For more information contact Cigna Secure Travel.

888-226-4567 (from the U.S. and Canada) / 202-331-7635 (from other locations)
cigna@europassistance-usa.com
Policy Number: 2044589
For additional details, see Appendix B.

Basic Accidental Death and Dismemberment Insurance ("AD&D")

Self-Funded; Covered by ERISA.

Eligibility

- Regular Employees, and
- Extended Part-Time Employees enrolled in the Plan on December 31, 2022 who continue to participate in the Plan.

Insurer

Connecticut General Life Insurance Company (CGLIC)

800-238-2125 (toll free)
412-402-3000 (international)

For additional details, see Appendix B.

Group Universal Life ("GUL") Insurance

Self-Funded; Covered by ERISA.

Eligibility

- Regular Employees,
- Extended Part-Time Employees enrolled in the Plan on December 31, 2022 who continue to participate in the Plan, and
- Other categories of individuals are eligible as specifically set forth in the Life Insurance Welfare Program Booklet.

Insurer

MetLife

800-GETMET8 (1-800-438-6388)
918-252-8616 (international)

For additional details, see Appendix B.

Voluntary Accidental Death and Dismemberment Insurance ("AD&D")

Self-Funded; Covered by ERISA

Eligibility

- Regular Employees, and
- Extended Part-Time Employees enrolled in the Plan on December 31, 2022 who continue to participate in the Plan.

Insurer

MetLife

800-GETMET8 (1-800-438-6388)
918-252-8616 (international)

AXA assistance USA, Inc (AXA)

Answers questions about the Emergency Travel Assistance Services features of Voluntary Accidental Death and Dismemberment Insurance

800-454-3679 (toll free)
312-935-3783 (international)

For additional details, see Appendix B.

Enrollment and Participation

How to enroll

As a newly hired Eligible Employee, you will receive enrollment materials from the ExxonMobil Benefits Service Center. If you wish to enroll, you have 30 days to do so after your start date for your coverage to begin retroactively to the first day of employment. For additional information regarding enrollment for long-term disability benefits, see the Disability Welfare Program Benefit Booklet. For additional information regarding life insurance, see the Life Insurance Welfare Program Benefit Booklet.

If no actions are taken within the time established, or as a current Eligible Employee you are not covered by a medical plan to which ExxonMobil contributes (even if previously enrolled and cancelled your coverage), the next opportunity to enroll will be during the Annual Enrollment Period, with coverage effective the first of the following year or upon a qualified mid-year change in status event with coverage being effective on the event date. See the Mid-Year Change in Status section below for additional details.

Participants can enroll/change benefits via Your Total Rewards Portal at the ExxonMobil Benefits Service Center and benefit representatives can provide specialized assistance.

ExxonMobil Business Service Center

Your Total Rewards portal (digital.alight.com/exxonmobil)

Alight Mobile app (available through Apple App Store or Google Play)

833-776-9966 (8am – 4pm CST, Monday through Friday, except certain holidays)

Dept 02694, PO Box 64116, The Woodlands, TX, 77387-4116

Dual Coverage

Dual coverage under the Plan is not permitted. You and a Spouse / Eligible Family Member cannot both enroll as employees and elect coverage for each other as Eligible Family Members. If you and your Spouse or adult Child work for the Corporation and both are eligible for coverage:

- Each of you can be covered as an individual employee; or
- One of you can be covered as the employee and the other can be an Eligible Family Member.

Also, if you and your Spouse have Children, each Child can only be covered by one of you.

In addition, a Marriage between two ExxonMobil Eligible Employees is not a qualified mid-year change in status event under the Plan. In order to change your coverage, you need to wait until you experience a change in status that allows coverage changes or the next Annual Enrollment Period.

Coverage Tiers

You can choose coverage as a:

- Participant only;
- Participant and Spouse;
- Participant and Child(ren); or
- Family.

Each coverage tier described in this section has its own contribution rate. Employees contribute to the Plan through monthly deductions from their pay on a pre-tax or, as approved by the Administrator-Benefits, on an after-tax basis.

Premiums and Contributions

The cost of the benefits provided through the Welfare Programs will be funded in part by payments called premiums (for fully insured plans) and contributions (for self-funded plans) out of the Corporation's general assets and in part by employee premiums and contributions (which may be pre-tax or after-tax, subject to the terms of the ExxonMobil Pre-Tax Spending Plan). The Corporation will determine and periodically communicate your share of the cost of the benefits provided through each Welfare Program, and it may change that determination at any time.

The Corporation will make payment of its premiums or contributions in an amount that (in the Corporation's sole discretion) is sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by employee premiums or contributions. With respect to fully insured Welfare Programs, the Corporation will pay its own premiums and employee premiums to the insurance carrier specified above. With respect to benefits that are self-funded, the Corporation will use its own contributions and employee contributions to pay benefits directly to or on behalf of you and your Eligible Family Members from the Corporation's general assets.

Employee contributions toward the cost of a particular benefit will be used in their entirety prior to using corporate contributions to pay for the cost of benefit.

Changing your coverage

To make a change to your coverage after your initial enrollment, you must wait until the next Annual Enrollment Period or until you experience a qualified mid-year change in status event.

Nondiscrimination

The Administrator-Benefits, in its discretion, may make such adjustments to certain contribution elections as may be necessary to satisfy applicable nondiscrimination rules under the Code. You will be notified of these limitations if you are affected.

Annual Enrollment

Each year, ExxonMobil offers an Annual Enrollment Period. During this time, you can switch from your current Plan options to another available option. This is also the time to make changes to coverage by adding or deleting Eligible Family Members. Changes elected during an Annual Enrollment Period take effect the first of the following year and must remain in place unless you experience a qualified mid-year change in status event.

During an Annual Enrollment Period, changes to your Plan coverage (options and contributions) do not automatically adjust your coverage or contributions to other Welfare Programs such as the ExxonMobil Dental Welfare Program, ExxonMobil Vision Welfare Program or the flexible spending accounts under the ExxonMobil Pre-Tax Spending Plan. Changes to those programs must be made separately. Welfare Program contributions will generally be made on a pre-tax basis.

Note: Do not wait until an Annual Enrollment Period to remove an Eligible Family Member who loses eligibility; they should be removed at the time eligibility is lost.

Mid-Year Changes in Status

If a qualified change in status event described in this section occurs, the participant may be permitted or required to:

- Enroll in coverage;
- Modify elections;
- End coverage; or
- Change the dependents covered.

The participant's new coverage election must be consistent with the qualified change in status event. If the actions permitted or required are not taken in the timeframes indicated, you may need to wait until the upcoming Annual Enrollment Period or another change in status event.

Changes to Medical, Behavioral Health and Prescription Drug, Dental and Vision Welfare Programs

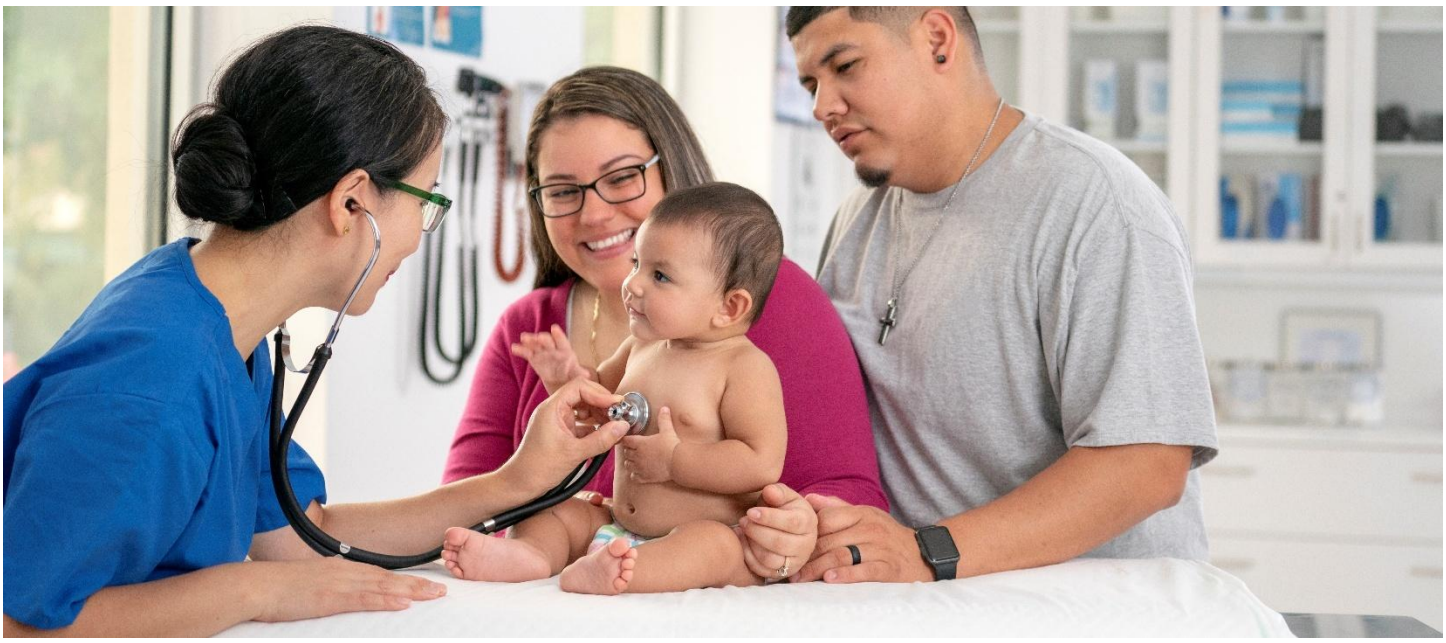
The following is a quick reference table that describes events which may allow changes, if the changes are submitted no later than 30 days after the event, as well as the actions you may take. If you have any questions, please call the ExxonMobil Benefits Service Center prior to the expiration of 30 days.

Events such as divorce or changes in eligibility related to premium assistance under Medicaid or the Children's Health Insurance Program ("CHIP") allow for a notification of up to 60 days.

Qualified change in status	You are required/permitted to	When
Divorce **Employee and Spouse enrolled in Plan**	You are required to remove coverage for your former Spouse and stepchild(ren) but you may not remove coverage for yourself or other covered Eligible Family Members. You must notify and provide any requested documents to the ExxonMobil Benefits Service Center as soon as your divorce is final. You may not make a change to your coverage if you and your Spouse become legally separated because there is no impact on eligibility.	You must make these changes within 60 days of your divorce and you are not required to show documentation to drop dependents. If you do not to notify the ExxonMobil Benefits Service Center within 60 days this will result in your former Spouse and stepchild(ren) not being entitled to elect COBRA. If you fail to remove your Spouse and any stepchild(ren) within 60 days of the event: • Coverage will be removed for the former Spouse and stepchild(ren) retroactive to the date of the divorce when the Plan discovers that a divorce has occurred; • The former Spouse and stepchild(ren) will not be eligible to elect COBRA; and • There will not be any refunds for the cancelled coverage.
Divorce - Employee loses coverage under Spouse's health plans	If you lose coverage under your Spouse's health plan because of divorce, you can sign up for medical coverage for yourself and your Eligible Family Members.	You must make these changes within 60 days following the date you lose coverage under your Spouse's plan.
Death of a Spouse or other Eligible Family Member	*Death of a Spouse*: You are required to remove coverage for your former Spouse, but you may not remove coverage for yourself or other covered Eligible Family Members. Note, however, that any stepchildren will cease to be eligible upon your Spouse's death unless you are their court appointed guardian or sole managing conservator. If you lose coverage under your Spouse's health plan, you can sign up for coverage for yourself and your Eligible Family Members. *Death of Child*: You are required to remove coverage for deceased Child but no other changes are allowed.	You must provide notice of your Spouse's death within 30 days of the date of death. No other election changes will be permitted for those currently enrolled in the Plan. If you were covered on your Spouse's plan you must make an election within 30 days of the date of death.
Other loss of family member's eligibility (e.g., sole managing conservatorship of grandchild ends)	Coverage continues through their last day of eligibility for any event the participant reports. In some cases, continuation coverage under COBRA may be available. See COBRA Continuation of Coverage section for more details about COBRA.	You must notify the ExxonMobil Benefits Service Center as soon as an Eligible Family Member is no longer eligible. If you fail to notify the ExxonMobil Benefits Service Center within 60 days, the Eligible Family Member will not be entitled to elect COBRA. You remain responsible for ensuring that the Child is removed from coverage. If you fail to ensure that an ineligible Family Member is removed in a timely manner, there may be consequences for falsifying company records.

Qualified change in employment status	You are required/permitted to	When
You lose eligibility because of a change in your employment status, e.g., Regular to Non-Regular or strike/ lockout	Your Plan participation will automatically be termed.	Last day of the month of the event
You gain eligibility because of a change in your employment status, (e.g. Non-Regular to Regular; Trainee to Regular).	Enroll yourself and add any Eligible Family Members. Since enrollment would not be upon original hire date, contributions would be on a post-tax basis if applied retroactively	You must make these changes within 30 days of the event.
Change in worksite or residence affecting eligibility to participate in the elected Medical, Dental and/or Vision Welfare Program options	Change your Plan option and change level of coverage, or cancel coverage for yourself or other Eligible Family Members.	
You begin or return from a LOA.	You may be able to make changes to some health plan benefits. Contact ExxonMobil Benefits Service Center at 833-776-9966 with any questions.	You must make these changes within 30 days following the date of the event.
You return from Expatriate assignment outside of the U.S.	If you are returning from an Expatriate assignment, you and your Eligible Family Members may choose a Medical, Dental, and/or Vision Welfare Program options, otherwise you may be automatically enrolled in the same or similar coverage options you had prior to your Expatriate assignment. You may cancel this coverage for yourself and your Eligible Family Members.	You must make these changes within 30 days of the event.
Termination of employment and rehire within 30 days or retroactive reinstatement ordered by court	If rehire is within 30 days or retroactive reinstatement ordered by court, you will be automatically enrolled in the same Medical, Dental, and/or Vision Welfare Program options you had prior to termination. If returning in a different plan year than termination, you can make any election changes. If rehire is after 30 days, enroll in all plans as new hire.	No action from the participant needed, automatic enrollment in same plan option. You must make election changes within 30 days following the date of the reinstatement. You must enroll within 30 days following the date of the reinstatement.
Termination of Employment by Spouse or other Eligible Family Member or other change in their employment status triggering loss of eligibility under the other plan	Enroll yourself and other Eligible Family Members who may have lost eligibility under the Spouse's or Eligible Family Member's plan in Plan and change your Plan options.	You must make these changes within 30 days following the date of the event.

Other qualified changes	You are required/permitted to	When
Another parent is ordered to provide coverage to your covered Child through a QMCSO	Revoke or decrease the affected Child's election if coverage actually provided. The effective date will be the date of qualification or end of month if termination date is not listed.	Within 30 days following the receipt of the QMCSO.
You are ordered to provide coverage to your eligible Child through a QMCSO	If you're currently enrolled, your Child will be automatically covered under your current options. If not currently enrolled, you and the affected Child will be covered automatically under the lowest cost option in the applicable plan(s). You can change your medical option.	These changes must be made within 30 days of the QMCSO.
Eligible dependent gains eligibility under another employer's plan	If the eligible dependent has or will obtain coverage under the other employer plan, remove them from coverage. You may also cancel coverage for yourself, if health care coverage is obtained through your Spouse's employer plan.	Within 30 days following the date of the event.
A significant change in coverage or cost* of your plan or your Spouse's plan. ***applies also to a significant increase in health care cost sharing.**	Make a corresponding prospective change in your election: *Change in coverage of this plan*: You can cancel or change your coverage. *Change in coverage of your Spouse´s plan*: you will be able to sign up for medical coverage for yourself and your Eligible Family Members. You can also change your medical option.	Within 30 days following the date of the event.



HIPAA special enrollment provisions	You are required/permitted to	When
Marriage	Enroll yourself and any Eligible Family Members. Drop coverage for yourself and your Eligible Family Members (if being covered by your new Spouse). Note that you cannot drop coverage for just your Eligible Family Members, if you wish to drop coverage it would be for the whole family. Change your medical plan options.	Within 30 days following the date of the event. Coverage is prospective.
Gain an Eligible Family Member through birth, adoption or placement for adoption	Enroll yourself and any Eligible Family Members Drop coverage for yourself and your Eligible Family Members. (Note that you cannot drop coverage for just your Eligible Family Members, if you wish to drop coverage it would be for the whole family.) Add any Eligible Family Members to your coverage. Change your medical option.	You must add the new Eligible Family Member within 30 days even if you already have family coverage. Coverage is effective on the date of birth, adoption, or placement for adoption.
You or a family member loses eligibility under another employer's group health plan	Enroll yourself and other Eligible Family Members who might have lost eligibility, add affected dependents and change medical plan options.	Within 30 days following the date of the event.
An Eligible Family Member's employer contributions cease.	Add affected dependents to your coverage. Change your medical plan options.	Within 30 days following the date of the event.
The participant or the participant's dependent loses or becomes eligible for premium assistance under Medicaid or CHIP.	If the participant is becoming eligible, they may drop coverage. If a dependent is becoming eligible, they may remove coverage for affected dependents only.	Within 60 days of either: termination of Medicaid or CHIP coverage due to loss of eligibility, or becoming eligible for a state premium assistance program under Medicaid or CHIP coverage.

Addition or improvement of Medical, Dental and/or Vision Welfare Program option

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

Loss of option

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

Other situations that may affect your coverage

Leaves of Absence

For Eligible Employees on an approved leave of absence ("LOA"), the following will apply:

Military leaves

- Mandatory / Required Military leave: coverage under the Plan continues during the entire duration of the leave at the employee contribution rate. You are not offered COBRA continuation coverage.
- Voluntary / Optional Military leave: coverage under the Plan will continue for up to 12 at the employee contribution rate. At the end of the 12-month period, your coverage under the Plan will end and you will have the opportunity to elect COBRA. The LOA does not reduce the duration of time you are eligible for COBRA.

Health/Dependent Care leave

Coverage under the Plan will continue for up to 6 months at the employee contribution rate. At the end of the 6-month period, your coverage under the Plan will end and you will have the opportunity to elect COBRA. The LOA does not reduce the duration of time you are eligible for COBRA.

Personal leave

Coverage under the Plan will continue for up to 12 months at the employee contribution rate. At the end of the 12-month period, your coverage under the plan will end and you will have the opportunity to elect COBRA. The LOA does not reduce the duration of time you are eligible for COBRA.

Note: depending on the type of leave, the 6 or the 12-month period of coverage at the employee contribution rate will be counted as of the start of the LOA, regardless if you are enrolled in a Welfare Program. If you were not enrolled and due to a change in status (e.g., a loss of other health plan coverage through Spouse), and you later enroll, the coverage at the employee contribution rate will be counted as of the start of the LOA and not as of the enrollment date.

When you are on an approved unpaid LOA, you will pay your contributions on an after-tax basis through direct debit (automatically taken from bank account) or direct bill (to be paid by check or with credit card). On the first day of the pay period available after you return to work, you will resume paying your contributions through pre-tax deductions.

You and the Corporation share the cost of your benefits. Information describing your share of the cost for each option during a Plan Year will be available at enrollment and throughout the Plan Year.

If you chose not to continue your coverage while on leave, your coverage ends on the last day of the month in which the cancelation form is received by ExxonMobil Benefits Service Center and you will be required to pay for the entire month's contributions. If you fail to make required contributions while on leave, your coverage will end. If your coverage under the Plan was cancelled during your LOA because you did not pay the contributions, you can make new benefit elections after you return to work—whether you return in the same or the following calendar year.

If the Corporation 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 Corporation for required contributions.

If you are on an approved LOA and you elect COBRA , you may continue your coverage by paying the required COBRA premiums.

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

For more information, contact ExxonMobil Benefits Service Center.

Retirement

If you retire as a Regular Employee on or after age 55 with 15 or more benefit years of service, you are eligible for the EMRMP or you may elect COBRA to stay in the Plan for the duration of COBRA Continuation Coverage. If you retire as a Regular Employee and are Medicare-eligible, you are eligible to enroll in Medicare Primary Option ("MPO") option of the EMRMP.

If you decline enrollment in the EMRMP at retirement, you will have limited opportunities to enroll at a later date. See the EMRMP SPD for more information.

If a covered Eligible Family Member lives away from home

Coverage depends on whether the Plan option you are enrolled in as an employee offers service in the area where you live. If your covered Eligible Family Member does not live with you (for instance, you have a Child away at school), please contact the appropriate Welfare Program Claims Administrator or Insurer to confirm whether service is available where your Eligible Family Member lives. See the Welfare Programs and Eligibility section for more information about the Plan's Claims Administrators and Insurers.

Your Medicare Eligibility

If you continue to work for a Participating Employer after you become eligible for Medicare, your Employer provided coverage remains in effect for you and Eligible Family Members and the Plan is your primary plan. Medicare benefits, if you sign up for them, will be your secondary benefits. Refer to www.medicare.gov to learn more about Medicare while you are still employed.

A Covered Family Member's Medicare Eligibility

Employees or Eligible Family Members of an Eligible Employee who become Medicare eligible, either due to age or Social Security disability status, are eligible to participate in Plan options as long as the Eligible Employee remains classified as a Regular Employee.

If the Eligible Employee retires or dies, coverage may be available under the EMRMP, as follows:

- Medicare eligible covered Spouses must enroll in the Medicare Primary Option, including enrolling in Medicare Parts A and B.
- All eligible dependent Children under the age of 26 (including those that are Medicare eligible) and those over the age of 26 who are totally and continuously disabled and not Medicare eligible, may enroll in the Retiree options of the EMRMP.

Medicare eligible dependent Children over the age of 26 are not eligible for coverage under any ExxonMobil Health plan available to Retirees. You may be eligible to elect continuation coverage for your Medicare eligible Child under COBRA provisions. See COBRA Continuation Coverage section for details.

Death

If you die while enrolled in the Plan, your Eligible Family Members may be able to continue their coverage as a Survivor/Surviving Spouse as follows:

Medical, Behavioral Health and Prescription Benefits

If the Eligible Family Member is enrolled in the Plan at the time of your death, the individual may elect to enroll in similar coverage offered under the EMRMP. For example, if the Eligible Family Member is

participating in the Medical, Behavioral Health and Prescription Drug Welfare Program at the time of your death, the Eligible Family Member may be treated as a Survivor/Surviving Spouse and elect to participate in one of the medical coverages under the EMRMP. They are not eligible to participate in this Plan except through COBRA.

Dental Benefits

If the Eligible Family Member is enrolled in the Dental Welfare Program at the time of your death, the individual may be treated as a Survivor/Surviving Spouse and elect to continue to participate in the Program.

Vision Benefits

If the Eligible Family Member is enrolled in the Vision Welfare Program at the time of your death, the individual may be treated as a Survivor/Surviving Spouse and elect to continue to participate in the Program.

Eligibility for your family member continues 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 Medicare or dies. Upon eligibility for Medicare, your Spouse can continue coverage through the Medicare Primary Option.
- 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 Medicare, or dies, whichever occurs first. Upon eligibility for Medicare, your Spouse can continue coverage through the Medicare Primary Option.

Children of deceased Eligible Employees may continue participation as long as they are an Eligible Family Member. If your Surviving Spouse remarries, eligibility for your stepchildren also ends.

Changes to your HCFSA

The Plan permits you to increase, decrease, revoke or elect to participate in the HCFSA during the Plan Year only as outlined in the chart below.

Changes in your elections must be consistent with the changes in status and the change must be made within 30 days of the event, except for the ones noted below.

Changes to the HCFSA	
Event	**Permitted Changes and Timing**
Marriage	Enroll or increase your election because of the newly eligible Spouse.
Divorce	Revoke or decrease your election because your Spouse is no longer eligible. For this change in status, you have up to 60 days from the date of the event to make updates.
Divorce - Employee loses coverage under Spouse's health plans.	Enroll or increase your election. For this change in status, you have up to 60 days from the date of the event to make updates.
Gain an Eligible Family Member through birth, adoption or placement for adoption, Marriage, or guardianship.	Enroll or increase your election because of the newly Eligible Family Member.
Move or change residence.	You are not eligible to make any changes.
Change in medical or your financial condition.	You are not eligible to make any changes.
Loss of family member's eligibility (e.g., no longer a tax dependent).	Revoke or decrease your election.
You lose eligibility because of a change in your employment status, (e.g., Regular to Non-Regular or you begin a LOA).	Revoke your election. You may continue the coverage during the leave on an after-tax basis until the end of the year in which the leave commenced.
You gain eligibility because of a change in your employment status, (e.g. Non-Regular to Regular).	Enroll.
Termination of Employment by Spouse or other Eligible Family Member or other change in their employment status (e.g., change from full-time to part-time) triggering loss of eligibility under Spouse or Eligible Family Member's plan.	Enroll or increase your election.
Your Eligible Family Member becomes eligible for Medicare or Medicaid.	Revoke or decrease your election. If becoming eligible for premium assistance under Medicaid or CHIP, changes can be done within 60 days of the date of the event.
Commencement of Employment by Spouse or other Eligible Family Member or other change in their employment status (e.g., change from part-time to full-time) triggering eligibility under Spouse or Eligible Family Member's plan.	May decrease or cease election if you gain eligibility under Spouse's or Eligible Family Member's plan. Your election to cease or decrease coverage for that individual (including yourself) corresponds only if coverage for that individual becomes effective or is increased under the other employer's plan.
Job transfer requiring relocation including one affecting eligibility to participate in the Plan.	You are not eligible to make any changes.
Provider no longer an available Plan option.	You are not eligible to make any changes.
Termination of employee and rehire within 30 days or retroactive reinstatement ordered by court.	Elections effective at termination are automatically restored unless another event has occurred which allows a change.
Termination of employment and rehire after 30 days.	Enroll as a new hire.
You are covered under your Spouse's medical plan and plan change's coverage to a lesser coverage with a higher deductible mid-year.	You are not eligible to make any changes.
You begin a LOA.	Contact the ExxonMobil Benefits Service Center to discuss permissible changes.

	You can continue or cancel your HCFSA contributions.
You return from a LOA.	If you return from a paid leave, no changes are allowed. If you return from an unpaid leave and: Maintained eligibility for coverage while on leave, you maintain current election. Lost eligibility or stopped making contributions, you will have no opportunity to make an election.
Death of a Spouse or other Eligible Family Member.	Revoke or decrease your election.
Death of a Spouse where employee is covered by Spouse's employer's group health plan.	Enroll or increase or decrease your election.
Judgment, decree or other court order requiring you to cover an Eligible Family Member (e.g., issuance of QMSCO).	Enroll or Increase your election.
Another parent is ordered to provide coverage to your Child through a QMSCO.	Revoke or decrease your election if coverage actually provided.
Start an Expatriate assignment and change from options available under the Plan to the ExxonMobil International Medical and Dental Plan	You are not eligible to make any changes.
You return from Expatriate assignment outside of the U.S.: If you return during the same Plan Year If you return in a different year from when your assignment began	There are no changes to your elections. You will be allowed to make a new election upon the end of the Expatriate assignment or increase current election.

Changes to your DCFSA

The DCFSA permits an Eligible Employee to increase, decrease, revoke or elect to participate in the DCFSA during the Plan Year only as provided in the following chart.

Changes in your elections must be consistent with the change in status and the change must be made within 30 days of the event except for the ones noted below.

Changes to the DCFSA	
Event	**Permitted Changes and Timing**
Marriage	Revoke or decrease your election (e.g., Spouse does not work and cares for the Children at home). Enroll of increase (e.g., Children are brought into family who now need daycare).
Divorce or Death of Spouse.	Enroll or increase (e.g., now need daycare). Revoke or decrease (e.g., stepchildren no longer qualifying Children). For divorce, you have up to 60 days to make updates.
Gain an Eligible Family Member through birth, adoption or placement for adoption, Marriage, or guardianship.	Enroll or increase your election if newly Eligible Family Member needs care.
Move or change residence.	You are not eligible to make any changes.
A family member is no longer considered an Eligible Family Member.	You can revoke or decrease your election (e.g., stepchildren no longer qualifying Children).
You or your Spouse change to or from part-time or full-time employment.	Enroll, increase, revoke or decrease your election.
You or your Spouse change work schedules which change either hours of dependent care required or the amount of dependent care costs.	Enroll, increase, revoke or decrease your election amount consistent with the change in dependent care costs.
Job transfer with or without relocation.	Enroll, increase, revoke or decrease your election amount only if the relocation results in a change to dependent care costs.
Change in the amount paid for dependent care.	Enroll, increase, revoke or decrease your election amount consistent with the change in dependent care costs (e.g., awarded a scholarship or other subsidy for childcare).
Change from one dependent care center to another one that charges a different rate.	Enroll, increase, revoke or decrease your election amount consistent with the change in qualified dependent care expense.
Your Child reaches age 13 and is no longer a qualifying family member.	Revoke or decrease your election amount consistent with the change in dependent care costs.
Change in home dependent care provider, (e.g., change to a nanny-sharing arrangement).	Enroll, increase, revoke or decrease your election amount consistent with the change in dependent care costs.

Changes to the DCFSA	
Event	**Permitted Changes and Timing**
Loss of family member's eligibility (e.g., no longer a tax dependent).	Revoke or decrease your election.
You lose eligibility because of a change in your employment status, (e.g., Regular to Non-Regular).	Revoke your election.
You begin a LOA.	You are not eligible for the DCFSA while on an unpaid LOA. If you are enrolled in the DCFSA, the elections will be cancelled at the end of the month in which you go on leave and any expenses incurred during your leave will not be eligible for reimbursement.
You return from a LOA of more than 30 days (paid or unpaid) during the same calendar year.	Contact the ExxonMobil Benefits Service Center. You have the right to reinstate coverage at prior coverage level or at a different level (in line with maximum annual deduction amount).
You return from LOA of more than 30 days (paid or unpaid) in the following calendar year.	You will be allowed to make a new election. Contact the ExxonMobil Benefits Service Center for further information.
Death of a qualifying family member.	Revoke or decrease (e.g., care no longer needed).

Leaves of Absence and FSA

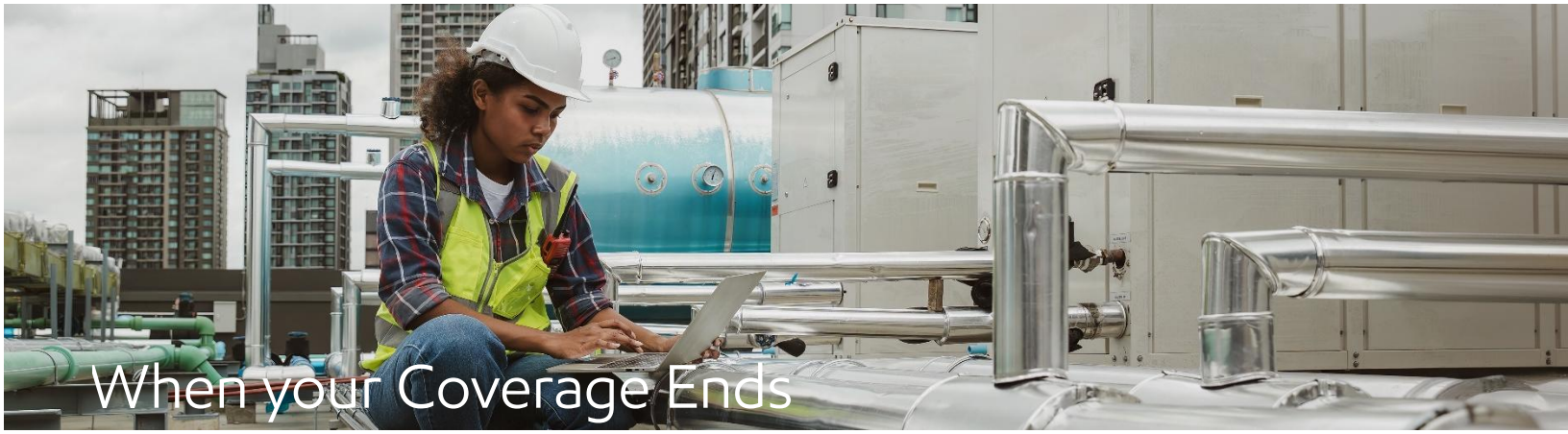
During a Leave of Absence you may not continue to participate in the DCFSA.

During a paid leave you may continue to participate in the HCFSA. You would continue your monthly contributions, file claims and receive reimbursement for eligible expenses, subject to claim filing deadlines. If you choose to continue participating in the HCFSA during an unpaid leave, you may continue to file claims and receive reimbursements for eligible expenses. Your contributions must be paid monthly on an after-tax basis during your leave. You can pay your health plan contributions on a post-tax basis through direct debit (automatically taken from bank account) or direct bill (to be paid by check or credit card). On the first day of the pay period available after you return to work, you will start paying your contributions through pre-tax deductions once more. If your health plan coverage was cancelled during your LOA because you did not pay the contributions, you can make new benefit elections after you return to work—whether you return in the same or the following calendar year.

You may also choose to revoke your election and discontinue your participation in the Plan. If you revoke your election while on a LOA, expenses you incur during the period of revocation will not be reimbursable from the Plan.

Leaves that last less than 30 days do not affect your eligibility to participate in the HCFSA. Such a leave is not a change in status which permits changes. Once you return to work, contributions will be adjusted for the time you were absent.

Upon return from a leave that lasts more than 30 days, if you return in the same calendar year, you will be reinstated to your prior HCFSA coverage at a level reduced pro rata for the missed contributions. For example, assume that Maria elected $1,200 in HCFSA coverage for the Plan Year and paid $100 per month for the coverage. On April 1, after submitting no claims for reimbursement, Maria begins a three-month leave. She does not elect to continue coverage. When Maria returns on July 1, she elects to re-enroll under HCFSA. She will have $900 reinstated ($1,200 minus $300 of paid contributions from January through March in missed contributions) at a cost of $150 per month for the remainder of the year. Expenses incurred during the period that the HCFSA was not in force are not eligible for reimbursement.



When your Coverage Ends

Generally, coverage for you and/or your Eligible Family Members ends on the earliest of:

The last day of the month in which:

- You terminate employment, retire, or die.
- A family member ceases to be eligible (for example, a Child reaches age 26).
- You terminate employment after being rehired by ExxonMobil as an employee following retirement.
- You do not make any required contribution.

OR

The effective date:

- The Plan ends.
- You enrolled an ineligible family member and in the opinion of the Administrator-Benefits, the enrollment was a result of fraud or a misrepresentation of a material fact.
- You elect not to participate anymore (opt out),
- You are no longer eligible for benefits under the Plan (e.g., from non-represented to represented where you are no longer eligible for this Plan; employee classification changes from Regular to Expatriate).
- A QMCSO is no longer in effect for a covered family member.
- Your Employer discontinues participation in the Plan.

You are responsible for ending coverage with the ExxonMobil Benefits Service Center when your enrolled Spouse or family member is no longer eligible for coverage. If you do not complete your change within 30 days for most changes in status (and 60 days in the case of divorce or if you, your Spouse or your covered dependent gains or loses eligibility for Medicaid or CHIP coverage), any contributions you make for ineligible family members will not be refunded.

Coverage for Welfare Programs may end earlier if termination of employment occurs in connection with a divestment or other corporate transaction, and the terms of the deal provide for an earlier coverage termination date.

Under some circumstances, you or your Eligible Family Members may continue coverage through COBRA continuation coverage. See the COBRA Continuation of Coverage section.

For coverage termination information for Basic Life Insurance and Group Universal Life Insurance, see [insert booklet links].

Non-payment of Premiums (For Retirees participating in the Dental and/or Vision Welfare Programs)

For Eligible Employees and Eligible Family Members, if your participation in any Plan Welfare Program component to which ExxonMobil contributed was suspended for non-payment of required contributions, you will not be able to reenroll until you repay all required contributions retroactively to the date of suspension.

If you are a Retiree, Eligible Family Member of Retiree or a Survivor and have missed payments, contact the ExxonMobil Benefits Service Center immediately for guidance in order to regularize your situation.

The cancellation and reinstatement process for Retirees, Eligible Family Members of a Retiree or a Survivor participating in the Dental, Vision, and/or other applicable Plan Welfare Program options is described below.

Cancellation of Retiree coverage due to non-payment of premiums

For Retirees, cancellations due to non-payment of applicable premiums will be prospective, with a 3-month grace period starting 1st month of unpaid contributions, so participants may pay owed contributions within that grace period to avoid cancellation. For example, if Retiree has not made payments for their January, February, and March premiums during that 3 month timeframe, coverage will be cancelled effective April 1.

Reinstatement of Retiree coverage

Once your coverage has been terminated, you can request to be reinstated upon showing good cause. Retiree requests for reinstatements will be reviewed on a case-by-case basis. If an individual has been involuntarily disenrolled for failure to pay Plan premiums, they may request reinstatement no later than 60 calendar days following the effective date of disenrollment.

Reinstatement for good cause will occur only when:

- Reinstatement is requested no later than 60 calendar days following the effective date of disenrollment (in the example, 60 days from April 1)
- The individual has been determined to meet the criteria specified below (i.e., receives a favorable determination); and
- Within three (3) months of disenrollment for nonpayment of plan premiums, the individual pays in full the plan premiums owed at the time they were disenrolled (in the example, within 3 months from April 1).

If you fail to pay premiums within the grace period, your coverage is terminated, and you fail to show good cause, you and your Eligible Family Members will not have an opportunity to re-enroll at a future date in the applicable Plan Welfare Program. You are still responsible for paying all owed premiums incurred during the grace period in which you were still part of the applicable Plan Welfare Program.

Requests for reinstatement must be accompanied by a credible statement (verbal or written) explaining the unforeseen and uncontrollable circumstances causing the failure to make timely payment. An individual may make only one reinstatement request for good cause in the 60-day period. Generally, these circumstances constitute good cause:

- A serious illness, institutionalization, and/or hospitalization of the member or their authorized representative (i.e. the individual responsible for the member's financial affairs), that lasted for a significant portion of the grace period for plan premium payment;

- Prolonged illness that is not chronic in nature, a serious (unexpected) complication to a chronic condition or rapid deterioration of the health of the member, a Spouse, another person living in the same household, person providing caregiver services to the member, or the member's authorized representative (i.e., the individual responsible for the member's financial affairs) that occurs during the grace period for the plan premium payment;
- Recent death of a Spouse, immediate family member, person living in the same household or person providing caregiver services to the member, or the member's authorized representative (i.e., the individual responsible for the member's financial affairs);
- Home was severely damaged by a fire, natural disaster, or other unexpected event, such that the member or the member's authorized representative was prevented from making arrangement for payment during the grace period for plan premium; or
- An extreme weather-related, public safety, or other unforeseen event declared as a Federal or state level of emergency prevented premium payment at any point during the plan premium grace period. For example, the member's bank or U.S. Post Office closes for a significant portion of the grace period.

There may be situations in addition to those listed above that result in favorable good cause determinations. If an individual presents a circumstance which is not captured in the listed examples, it must meet the regulatory standards of being outside of the member's control or unexpected such that the member could not have reasonably foreseen its occurrence, and this circumstance must be the cause for the non-payment of plan premiums. The Plan expects non-listed circumstances will be rare.

Examples of circumstances that do not constitute good cause include:

- Allegation that bills or warning notices were not received due to unreported change of address, out of town for vacation, visiting out of town family, etc.;
- Authorized representative did not pay timely on member's behalf;
- Lack of understanding of the ramifications of not paying plan premiums;
- Could not afford to pay premiums during the grace period; or
- Need for prescription medicines or other plan services.

The ExxonMobil Business Service Center is the appointed designee reviewing reinstatement requests and making good cause determinations.

Rescission in Event of Fraud

Any act, practice, or omission by a Plan participant that constitutes fraud or an intentional misrepresentation of material fact is prohibited by the Plan, and the Plan may rescind coverage retroactively as a result. Any such fraudulent statements, including on Plan enrollment forms (e.g., enrolling Children that do not meet eligibility requirements) and in electronic submissions, may invalidate any payment or claims for services and may be grounds for rescinding coverage.

You may be subject to disciplinary action up to and including termination of employment if you commit fraud against the 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 Plan on your behalf or which you recover from a third party. Your participation may be terminated if you fail to comply with the terms of the Plan and its administrative requirements. This includes failing to provide timely notification of when a covered family member loses eligibility, e.g. Spouse loses eligibility due to divorce.

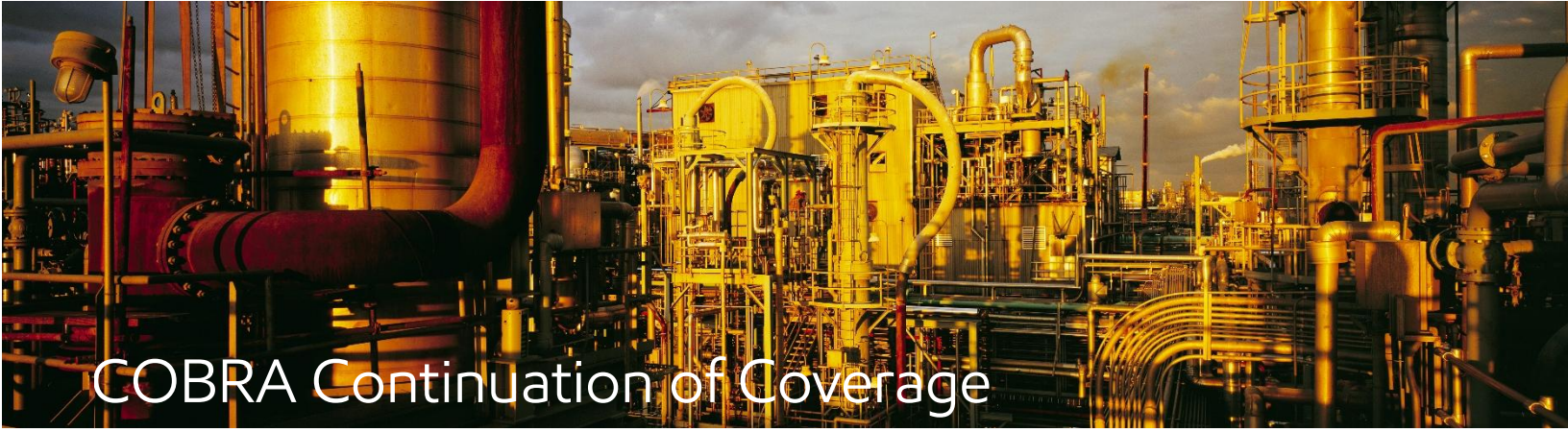
Extended benefits at termination

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

Several conditions must be met:

- The disability must exist when your employment terminates.
- The extension lasts only as long as the disability continues, but no longer than 12 months.

This extension applies only to the employee who is terminated because of a disability. Continuation coverage for Eligible Family Members may be available through COBRA.



COBRA Continuation of Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") provides for continuation of certain benefits for "qualified beneficiaries" who lose their coverage due to a "qualifying event." This section summarizes your rights and obligations under COBRA. For additional information about your rights and obligations under COBRA, please contact the ExxonMobil Benefits Center.

Benefits You May Continue

The Plan benefits subject to COBRA include medical, prescription drug, dental, vision, EAP, wellness and access to onsite clinic services. You and your Eligible Family Members will be offered the same medical, prescription drug, dental, vision, EAP, wellness and onsite clinic coverage that you had the day before the qualifying event that caused you to lose coverage under the Plan.

Under certain conditions, you may continue participation and contributions to your HCFSA for the remainder of the Plan Year. Please contact the COBRA Administrator at:

Alight PO Box 1438
Lincolnshire, IL 60069
855-250-4170

You may also see the HCFSA Benefit Booklet for additional information.

What is COBRA Continuation Coverage

COBRA continuation coverage applies when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse, and your Children could become qualified beneficiaries if you lose coverage under the Plan because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for the costs of the coverage.

Other Coverage Options

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees. You can learn more in the *Health Insurance Marketplace* section below.

Who's Eligible for COBRA

Employee Continuation Coverage

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

Spouse Continuation Coverage

Your Spouse will become a qualified beneficiary if he or she loses coverage under the Plan because any of the following qualifying events happen:

- The employee 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's entitlement to Medicare (under Part A, Part B, or both); or
- The employee becomes divorced from his or her Spouse.

Child Continuation Coverage

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

- The parent-employee 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 becomes entitled to Medicare benefits (Part A, Part B, or both); or
- The Child is no longer eligible for coverage under the Plan as a Child.

When COBRA Continuation Coverage is Available

To be eligible for COBRA continuation coverage, the qualified beneficiaries must notify the COBRA Administrator of certain qualifying events (e.g., divorce or the Child ceasing to meet the Plan's eligibility criteria), as specified below. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer will notify the COBRA Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For qualifying events such as divorce of the employee and Spouse or a Child losing eligibility for coverage under the Plan, you must notify the ExxonMobil Benefits Service Center in writing within 60 days of the date of the qualifying event.

Please note: Notice is not effective until either a change is made on the Your Total Rewards portal or the proper information is received by the ExxonMobil Benefits Service Center. If notice is not submitted during the 30 or 60-

day notice period, depending on the change in status event, then all qualified beneficiaries will lose their right to elect coverage continuation rights that are otherwise available under COBRA.

How COBRA Continuation Coverage Is Provided

Once the COBRA Administrator 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. For example, the employee's Spouse may elect COBRA Continuation Coverage even if the employee does not. COBRA continuation coverage may be elected for only one, several, or for all Children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any Children. The employee or the employee's Spouse can elect COBRA Continuation Coverage on behalf of all of the qualified beneficiaries.

You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after your coverage under the Plan ends because of one of the qualifying events listed above. You also have the same special enrollment right at the end of the COBRA continuation coverage period if you enroll in COBRA continuation coverage.

Please note: Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice will lose their right to elect coverage continuation rights that are otherwise available under COBRA.

How Long Cobra Continuation Coverage Lasts

COBRA continuation coverage is a temporary continuation of coverage. The COBRA continuation coverage periods described below are the maximum coverage periods. COBRA Continuation Coverage can end before the end of the maximum coverage period for several reasons, which are described below in Termination of COBRA Continuation Coverage.

18-month Period of COBRA Continuation Coverage

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage can last 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 or a second qualifying event.

Disability Extension of 18-month Period of COBRA Continuation Coverage

An 11-month extension of coverage may be available if the Social Security Administration (SSA) determines that any of the qualified beneficiaries are disabled. The disability must 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 COBRA continuation coverage. You must notify the COBRA Administrator in writing and provide a copy of the SSA determination within 60 days after the latest of:

- The date of the SSA disability determination; or
- The date of the covered employee's termination of employment or reduction of hours.

Notice must also be provided within 18 months after the covered employee's termination of employment or reduction of hours for entitlement to a disability extension.

Each qualified beneficiary who has elected COBRA continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is later determined by SSA to no longer be disabled, you must notify the COBRA Administrator of that fact within 30 days after SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to Spouses and dependent Children who elect COBRA continuation coverage if a second qualifying event occurs during the first 18 months of COBRA continuation coverage. The maximum amount of COBRA continuation coverage available when a second qualifying event occurs is 36 months. Second qualifying events include the death of a covered employee, divorce, or a Child's ceasing to be eligible for coverage as a dependent under the Plan. These events are a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the COBRA Administrator in writing within 60 days after a secondary qualifying event occurs if you want to extend your COBRA Continuation Coverage.

This extension is not available when a covered employee becomes entitled to Medicare after the termination of employment or reduction of hours.

In no event will your federal COBRA Continuation Coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage.

COBRA And Long-Term Military Leave

If you and your dependents are currently enrolled in the Plan, the Corporation will continue your current health coverage under the Plan for the first 365 days of your approved long-term military leave of absence. When you reach your 366th day of your leave, you will be sent a Notice of Right to Elect USERRA Continuation Coverage. You will have 60 days from the date of the notice to elect to continue your coverage due to your long-term military leave of absence. This continuation period may continue during the period of your military service, up to a maximum of 24 months (unless one of your dependents has a second qualifying event during that 24-month period). You will be responsible for paying the full premium amount as long as your USERRA continuation coverage is in effect up to the maximum period of 24 months.

COBRA and Medicare

When coverage is lost due to termination of employment or reduction of the employee's hours of employment and the employee becomes entitled to Medicare less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the employee's qualifying event can last up to 36 months after the date of the Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her 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). This extension is available only if the covered employee becomes entitled to Medicare before the termination of employment or reduction of hours.

Family and Medical Leave Act

Employees on a Family and Medical Leave Act leave of absence who terminate employment during the leave, or fail to return to work following such leave, will be eligible to continue coverage for up to 18 months from the date employment terminated or the date the approved leave ends.

COBRA and Other Coverage

Coverage for a person who has elected COBRA continuation coverage under this Plan will be secondary if the person is covered by any other group health plan.

Termination of COBRA Coverage

COBRA Continuation Coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan;
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage;
- The Employer ceases to provide any group health plan for its Eligible Employees; or
- The individual whose SSA disability provided for a disability extension is no longer disabled.

Continuation coverage under COBRA is provided subject to your eligibility for coverage. The Administrator-Benefits reserves the right to terminate your COBRA continuation coverage retroactively if you are determined to be ineligible. COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

New Children as Qualified Beneficiaries

A Child who is born to or placed for adoption with the Covered Person during a period of COBRA continuation coverage will be eligible to become a qualified beneficiary. You must advise the COBRA Administrator in writing of the birth or adoption within 60 days of the Child's birth or placement for adoption.

Cost of COBRA Continuation Coverage

Your Premium Costs

Generally, each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The amount a qualified beneficiary will be required to pay will not exceed 102% (or, in the case of an extension of COBRA continuation coverage due to a disability, 150%) of the cost to the Plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage.

Premium rates are subject to change each January 1.

First Payment for COBRA Continuation Coverage

If you elect COBRA continuation coverage, you do not have to send any payment when you submit your election. However, you must make your first payment for COBRA continuation coverage not later than 45 days after the date of your election. (This is the date your COBRA election notice is post-marked, if mailed.) If you do not make your first payment for COBRA continuation coverage in full within 45 days after the date of your election, you will

lose all COBRA continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You will be provided with information detailing the amount and due dates of the initial and subsequent monthly payments. You may also contact Alight, your COBRA Administrator at PO Box 1438 - Lincolnshire, IL 60069 to confirm the correct amount of your first payment.

Periodic Payments for COBRA Continuation Coverage

After you make your first payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent month of coverage (known as the coverage period). Under the Plan, each payment for COBRA continuation coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods, but you will be provided with monthly premium coupons.

Grace Periods for Periodic Payments

Although periodic payments are due as explained above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan. Late payment will result in your permanent loss of coverage.

Changes in the Plan

If there are changes or modifications to the Plan affecting a Covered Person, those changes also apply to individuals receiving COBRA continuation coverage, whether in improvements or reductions in benefits.

Questions About COBRA Continuation Coverage

The right to COBRA continuation coverage is protected by law. If the law changes, your rights will change accordingly. If you have any questions about COBRA continuation coverage, please contact the COBRA Administrator. Also, if your marital status or address (or your Spouse's address) have changed please notify the COBRA Administrator.

The Health Insurance Marketplace

The Health Insurance Marketplace ("Marketplace") offers one-stop shopping to find and compare private health insurance options. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance and copayments) right away, and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or CHIP. You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

Filing Claims and Appeals

All claims and appeals for benefits should be directed to the appropriate Insurer or Claims Fiduciary listed in the Welfare Programs and Eligibility section. Eligibility claims should be directed to the Administrator-Benefits, ExxonMobil Health and Welfare Plan, DEPT 02694, PO Box 64116, The Woodlands, TX, 77387-4116.

Claims for Benefits: Deadline to File Claims

Unless otherwise provided in the applicable Welfare Program, you must file a claim for benefits within 365 days following the date the service was rendered. All uninsured death benefit claims, Basic Life Insurance claims and Group Universal Life claims should be filed within ten years of the date of death. You should file your claim for benefits with the applicable Insurer or Claims Administrator listed in the Welfare Programs and Eligibility section. Any claim for uninsured death benefits should be filed with the Administrator-Benefits.

Claims for Benefits: Initial Claims

Unless otherwise provided in the applicable Welfare Program, your claim for benefits will be processed under the procedures described below. If applicable, Insured benefits will be decided by the Insurer listed in the Health Welfare Programs and Eligibility section. Self-funded benefits will be decided by the Claims Administrator listed in the Health Welfare Programs and Eligibility section. Any claims or appeals related to an uninsured death benefit denial should be filed with the Administrator-Benefits.

Note: the procedures listed below are default appeal procedures and apply only when the applicable Welfare Program does not provide for a specific appeal procedure. Where it does, you must follow the specific appeal procedure provided there.

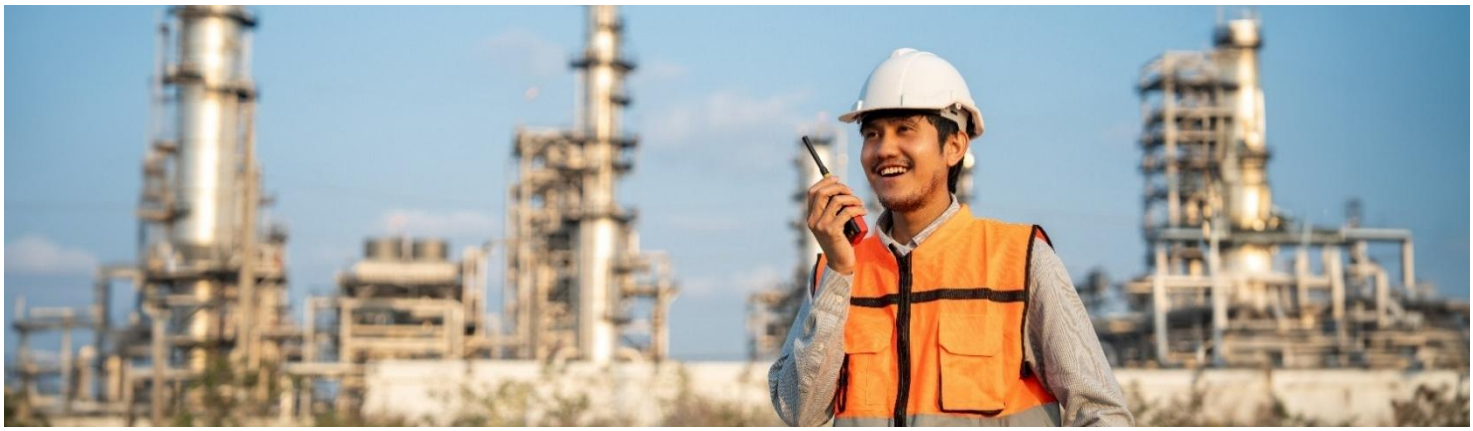
Initial Claims

Medical, Behavioral Health, Prescription Drug, Dental, Vision, EAP, and other Welfare Programs subject to ERISA Claims Procedures	
Claim Types	**Timing**
Urgent Claims Any claim for medical care or treatment where making a determination under the normal timeframes could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.	Notice of the Plan's determination will be sent as soon as possible considering the medical exigencies, and in no case later than 72 hours after receipt of the claim. You may receive notice orally, in which case a written notice will be provided within 3 days of the oral notice. If your urgent claim is determined to be incomplete, you will receive a notice to this effect within 24 hours of receipt of your claim, at which point you will have 48 hours to provide additional information. If you request an extension of urgent care benefits beyond an initially determined period and make the request at least 24 hours prior to the expiration of the original determination, you will be notified within 24 hours of receipt of the request.
Pre-Service Claims A claim for services that have not yet been rendered and for which the Plan requires prior authorization.	If your pre-service claim is improperly filed, you will be sent notification within five days of receipt of the claim. If your pre-service claim is filed properly, a claims determination will be sent within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days from receipt of the claim. If the Insurer or Claims Administrator determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the Insurer or Claims Administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Insurer or Claims Administrator then will make its determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.
Post-Service Claims A claim for services that already have been rendered, or where the Plan does not require prior authorization.	Notice of the Plan's determination will be sent within a reasonable time period but not longer than 30 days from receipt of the claim. If the Insurer or Claims Administrator determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the Insurer or Claims Administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Insurer or Claims Administrator then will make its determination within

	15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.

Disability Claims	
Claim Types	**Timing**
STD and LTD	Notice of the Plan's determination will be sent within a reasonable time period, but not longer than 45 days from receipt of the claim. If the Insurer or Claims Administrator determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended for two additional 30-day periods. You will receive notice prior to each extension that indicates the circumstances requiring the extension, the date by which the Insurer or Claims Administrator expects to render a determination, the standards on which entitlement to a benefit is based, and the unresolved issues that prevent a decision on the claim. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Insurer or Claims Administrator then will make its determination within 30 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.

Basic Life Insurance, Basic AD&D Insurance, Group Universal Life Insurance, Voluntary AD&D Insurance, and Uninsured Death Benefit Claims	
Claim Types	**Timing**
Life Insurance Claims	Notice of the Plan's determination will be sent within a reasonable time period, but no later than 90 days from receipt of the claim. If the Insurer, Claims Administrator or Administrator-Benefits determines that an extension is necessary due to special circumstances, this time may be extended for an additional 90 days. You will receive notice prior to the extension that indicates the special circumstances requiring the extension and the date by which the Insurer, Claims Administrator or Administrator-Benefits expects to render a determination.



DCFSA Claims	
Claim Types	**Timing**
Dependent Care Flexible Spending Account Claims	While not subject to ERISA, ExxonMobil permits you to submit DCFSA claims under the ERISA claims procedures. Notice of the Plan's determination will be sent within a reasonable time period but not longer than 30 days from receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the Claims Administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Claims Administrator then will make its determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.

Claims for Benefits: Mandatory Appeals

Refer to the Welfare Program Documents for procedures to file claim for benefits or related appeal.

Unless otherwise stated in the applicable Welfare Program Documents, you must file your appeal related to a specific coverage, treatment, eligibility determination, or benefit within the deadline set out in the chart below. Requests for appeals should be sent to the address specified in the denial notice.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal, and you will have access to all documents that are relevant to your claim. Your appeal will be conducted by a person different from the person who made the initial decision. No deference will be afforded to the initial determination.

If your claim involves a medical judgment question, the Insurer or Claims Administrator will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, the Insurer or Claims Administrator will provide you with the identification of any medical expert whose advice was obtained on behalf of the Plan in connection with your appeal.

A final decision on appeal will be made within the time periods specified below.

Note: the procedures listed below are default appeal procedures and apply only when the applicable Welfare Program does not provide for a specific appeal procedure. Where it does, you must follow the specific appeal procedure provided there.

Mandatory Appeals Medical, Behavioral Health, Prescription Drug, Dental, Vision, EAP, and other Welfare Programs subject to ERISA Claims Procedures	
Claim Types	**Timing**
Urgent Claims	You must submit your appeal within 180 days of the date of your initial denial notice (or first level appeal notice, for second level appeals). You will be notified of the determination as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
Pre-Service Claims	You must submit your appeal within 180 days of the date of your initial denial notice (or first level appeal notice, for second level appeals). For both the first and second levels of appeal of a Pre-Service claim, you will be notified of the determination within a reasonable period of time taking into account the medical circumstances, but no later than 15 days from the date your request is received (30 days if there is only one level of appeal).
Post-Service Claims	You must submit your appeal within 180 days of the date of your initial denial notice (or first level appeal notice, for second level appeals). For both the first and second levels of appeal of a Post-Service claim, you will be notified of the determination within a reasonable period of time, but no later than 30 days from the date your request is received (60 days from the date if there is only one level of review).

Mandatory Appeals Disability Claims	
Claim Types	**Timing**
STD and LTD	You must submit your appeal within 180 days of the date of your initial denial notice. You will be notified of the determination within a reasonable time, but not later than 45 days from receipt of the request for review. If the Insurer or Claims Administrator determines that an extension is necessary due to special circumstances, this time may be extended for an additional 45 days. You will receive notice prior to the extension that indicates the special circumstances requiring the extension and the date by which the Insurer or Claims Administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Insurer or Claims Administrator then will make its determination within 45 days from the date it receives your information, or, if earlier, the deadline to submit your information

Mandatory Appeals Life Insurance Claims	
Claim Types	**Timing**
Life Insurance Claims	You must submit your appeal within 60 days of the date of your initial denial notice. You will be notified of the determination within a reasonable time, but no later than 60 days from receipt of the request for review. If the Insurer, Claims Administrator or Administrator-Benefits determines that an extension is necessary due to special circumstances, this time may be extended for an additional 60 days. You will receive notice within the 60-day appeal period that indicates the special circumstances requiring the extension and the date by which the Insurer, Claims Administrator or Administrator-Benefits expects to render a determination.

Mandatory Appeals DCFSA Claims	
Claim Types	**Timing**
Dependent Care Flexible Spending Account Claims	While not subject to ERISA, ExxonMobil permits you to appeal DCFSA denials under the ERISA claims procedures. You must submit your appeal within 180 days of the date of your initial denial notice. The review will take into account all comments, documents, records and other information submitted relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Claims Fiduciary will respond to the appeal within 60 days.

Claims for Benefits: Voluntary Appeals for Uninsured Death Benefit and Disability Claim Denials

If an appeal for an uninsured death benefit or disability claim is denied, a voluntary appeal to the Administrator-Benefits may be available. New information pertinent to the claim is required for the voluntary appeal to be considered. You must submit your voluntary appeal within 30 days of the denial of your mandatory appeal. The statute of limitations or other defense based on timeliness is suspended during the time that a voluntary appeal is pending. You will be notified within 15 days after your request was received that such information was considered or is not pertinent. If it is determined that there is new relevant information, a decision will be made within 60 days after the Administrator-Benefits receives your request for a voluntary appeal. If it is determined that there is no new information pertinent to your claim, your voluntary appeal will not be considered.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by amendment or termination) before the end of such period of time or number of treatments will constitute an adverse benefit determination. You will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction so that you will be able to appeal the decision before the coverage is reduced or terminated.

If the claim is a request for an urgent extension of concurrent care and the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, you will be notified of the decision, whether adverse or not, as soon as possible but no later than 24 hours after receipt of the claim. If your request for extended treatment is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as an urgent care claim and decided according to the urgent care time frames listed above.

If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the Plan does not involve urgent care, your request will be considered a new claim and will be decided according to pre-service or post-service timeframes, whichever applies.

Appeals of concurrent care claims will be governed according to applicable timeframes (urgent care, pre-service, or post-service) listed in the tables above.

Claims for Benefits: Notice of Determination

If your claim or appeal is in part or wholly denied, you will receive notice of an adverse benefit determination that will:

- state specific reason(s) of the adverse determination;
- reference specific Plan provision(s) on which the benefit determination is based;
- describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary (initial claim only);
- describe the Plan's claims review procedures and the time limits applicable to such procedures (initial claim only);
- include a statement of your right to bring a civil action under section 502(a) of ERISA following appeal and any applicable contractual limitations period that applies to the claimant's right to bring such an action and the calendar date on which the contractual limitations period expires for the claim;
- state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits (appeal only for Medical claims; appeal only for Disability claims)
- describe any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures (appeal only);
- disclose any internal rule, guidelines, or protocol relied on in making the adverse determination (or state that such information will be provided free of charge upon request);
- if the denial is based on a medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);
- include information sufficient to identify the claim involved, including date of service, health care provider, and claim amount (for Medical claims);

- include the denial code and corresponding meaning (for Medical claims);
- include a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning (for Medical claims);
- describe the Claims Administrator's or Insurer's standard, if any, used in denying the claim (for Medical claims);
- describe the external review process, if applicable (for Medical claims);
- include a statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under health care reform laws to assist individuals with internal claims and appeals and external review processes (for Medical claims);
- include a discussion of the decision, including an explanation of the basis for disagreeing with or not the following: (i) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration (for Disability claims and appeals); and
- include either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist (for Disability claims and appeals).

For initial claims, you also will receive notification of approval if your claim is an urgent or pre-service claim. For appeals, you will receive a notice if your appeal is approved.

External Review

If you are not satisfied with the Claims Administrator's decision on your internal appeal review and the appeal involves medical judgment, a rescission of coverage, or an adverse determination for surprise bills (medical and air ambulance bills, including a determination of whether an adverse determination is subject to surprise billing provisions), you may request that your appeal be referred to an Independent Review Organization ("IRO"). Your external review will be conducted by an independent review organization not affiliated with the Plan. This independent review organization may overturn the Plan's decision, and the independent review organization's decision is binding on the Plan. Your appeal denial notice will include more information about your right to file a request for an external review and contact information. You must file your request for external review within four months of receiving your final internal appeal determination. Filing a request for external review will not affect your ability to bring a legal claim in court. When filing a request for external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review. See your Welfare Program Documents referenced in Welfare Programs and Eligibility section for more information.

Deadline to Bring Legal Action

You may not bring a lawsuit to recover benefits under this Plan until you have exhausted the administrative process described in this section and/or as listed in your Welfare Program. No action may be brought at all unless brought no later than one year following a final decision on your claim for benefits, unless a shorter period is limited in your Welfare Program (in which case that time period controls). This statute of limitations on suits for all benefits shall apply in any forum where you may initiate such suit.

Coordination of Benefits

Coordination with Other Plans

Unless otherwise specified in the applicable Welfare Program, the Plan will coordinate benefits with any other group health plan that covers you or your Eligible Family Members under the rules below.

Other group health plans with which the Plan will coordinate include:

- other employer group health plan coverage for you or your Eligible Family Member;
- group, blanket, or franchise insurance coverage;
- no-fault motor vehicle laws;
- hospital service prepayment plan on a group basis, medical service prepayment plan on a group basis, group practice, or other prepayment coverage on a group basis;
- coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
- as permitted by law, any coverage, including Medicare, under any tax-supported or government program.

The rules below determine whether this Plan or another plan will pay primary (first) or secondary. In no case will you be entitled to benefits totaling more than 100% of the covered charges incurred or, where this plan pays primary, the covered charges otherwise payable under this Plan.

Order of Benefit Determination

1. If the other plan does not have a coordination of benefits provision, it is the primary plan.
2. If the first plan covers a person as other than a dependent and the second plan covers such person as a dependent, the first plan is the primary plan, where permitted by law.
3. If both plans cover a dependent, the plan of the enrollee whose birthday occurs earlier in the calendar year is the primary plan.
4. If the first plan covers a Child of divorced or separated parents as a dependent of the parent whom a court has declared to be responsible for the Child's health care, the first plan is the primary plan. However, if no court decree is in effect, the following rules apply:
   - if the first plan covers the Child as a dependent of the parent who has custody of the Child and such parent has not remarried, the first plan is the primary plan; and
   - if the first plan covers the Child as a dependent of the parent who has custody of the Child and such parent has remarried, the first plan and the plan of the stepparent are each considered the primary plan;
5. If the first plan covers a person as an active employee or as a dependent of an active employee and the second plan covers such person as a retired or laid-off employee or as a dependent of a retired or laid-off employee, the first plan is the primary plan.

6. If a person is receiving continuation coverage under this Plan and is also covered under another plan, the following shall be the order of benefit determination: first, the benefits of a plan covering the person as an Eligible Employee (or as the person's dependent); and second, the benefits under the continuation coverage. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If the rules above do not establish a primary plan and a secondary plan, the plan that has covered the individual for the longer period of time is the primary plan.

Facility of Payment

If any other group health plan provides or pays benefits that should have been provided or paid under this Plan, the Plan has the right to pay over to the other plan the amount the Plan Administrator determines is necessary to satisfy this coordination of benefit provision. These amounts are considered benefit payments under this Plan and will operate to discharge the Plan from liability to the extent of such payments.

Right of Recovery / Subrogation

Immediately upon payment of any benefits under the Plan, the Plan shall be subrogated to: (1) all rights of recovery a Covered Person has against any party whose conduct or action caused or contributed to the loss for which payment was made by the Plan or (2) any party who has received payments on behalf of a Covered Person for injury or illness from any source by way of settlement, judgment, or any other means, including but not limited to worker's compensation coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, no-fault automobile insurance coverage or homeowners insurance. "Covered Person" include anyone on whose behalf the Plan pays or provides any benefit including, but not limited to, the minor Child or dependent of any Plan member or person entitled to receive any benefits from the Plan. If a Covered Person receives any reimbursement or other payment from any party as a result of an injury or illness, the Plan shall have a first dollar priority claim, to the extent of benefits advanced, upon any amounts that the Covered Person recovers from any party, whether by settlement, judgment or otherwise. The Plan will be entitled to recover these amounts whether or not the monies that a Covered Person receives from a third party are designated as medical expenses.

Similarly, if any person, including any natural person or entity, other than the Covered Person has possession of funds recovered from a third party as to which the Covered Person has a claim, then the Plan shall be subrogated to the Covered Person's claim and shall have a right to recover directly from the person that is holding the funds on behalf of the Covered Person. In that event, the Covered Person shall assist the Plan in its attempt to recover from that person. In the event that a Covered Person is deceased, the Plan shall have a right to recover funds from the estate pursuant to this reimbursement provision.

The Covered Person and individuals acting on his or her behalf, including attorneys, shall do nothing to prejudice the Plan's subrogation and reimbursement rights and shall, when requested, provide the Plan with information and cooperate with the Plan in the enforcement of its subrogation and reimbursement rights. It is the duty of the Covered Person and individuals acting on the Covered Person's behalf, to notify the Contract Administrator within 45 days of the date of the injury or the date when the Covered Person, or persons acting on his or her behalf, gives notice to any other party, including an attorney, of their intention to pursue or investigate a claim to recover damages on behalf of the Covered Person.

By accepting any benefits advanced by the Plan under this section, the Covered Person acknowledges that any proceeds of settlement or judgment, including a Covered Person's claim to such proceeds held by another person,

held by the Covered Person or by another, are being held for the benefit of the Plan under these provisions. If the Plan advances moneys or provides benefits for an injury, sickness, or other conditions, and the Covered Person recovers moneys or benefits from a third party in the amount of the moneys or benefits advanced, the Plan has an equitable lien in connection with any such payments. Failure to hold such received funds in trust, and in a separate, identifiable account, will be deemed a breach of the Covered Person's fiduciary duty to the Plan.

The Plan's subrogation and reimbursement rights are a first priority claim against all potentially liable parties and are to be paid before any other claim for the Covered Person's general damages, including attorney's fees and costs. The Plan shall be entitled to reimbursement regardless of any state's made-whole doctrine, i.e. even if the payments received by the Covered Person from any or all parties are insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Plan shall be responsible only for those legal fees and expenses to which it agrees in writing. No Covered Person hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder. Specifically, no court costs or attorney's fees may be deducted from the Plan's recovery without the express written consent of the Plan. Any so-called "Fund Doctrine," "Common Fund Doctrine," "Attorney's Fund Doctrine," or other equitable defenses shall not defeat this right. In addition, the Plan's subrogation and reimbursement rights shall not be reduced or limited in any way by a Covered Person's actual or alleged comparative fault or contributory negligence in causing the injury or sickness for which the Plan has paid benefits.

This entire subrogation and reimbursement provision will apply whether or not liability for payment is admitted by any potentially responsible party. In the event that a Covered Person refuses to reimburse this Plan in accordance with the terms of this provision, the Plan has the right to deduct the amount of benefits paid from any future benefits payable to the Covered Person and may bring an action under ERISA, to recover funds from the Covered Person or against the Covered Person's estate or any other person that is holding funds on behalf of the Covered Person.

If a third-party reimbursement is made to a Covered Person before benefits under this plan are paid, the maximum benefit payable will be limited to the amount, if any, in excess of the third-party reimbursement.

The Administrator- Benefits in his or her sole and absolute discretion may waive or modify any or all of the provisions of this rule.

Other Legal Information

Applicable Law

The Plan and all rights hereunder are governed by and construed, administered, and regulated in accordance with the provisions of ERISA, HIPAA, and the Code to the extent applicable, and to the extent not preempted by ERISA, the laws of the state of Texas, without giving effect to its conflicts of laws provision. The Plan may not be interpreted to require any person to take action, or fail to take any action, if to do so would violate any applicable law.

Forum and Venue

The exclusive forum and venue for any legal or equitable action relating to or arising under the plan shall be in the United States District Court for the Southern District of Texas, Houston Division, so long as the federal courts may assert subject matter jurisdiction over the action (unless the parties to the action have agreed otherwise). In the event the action is not subject to the subject matter jurisdiction of the federal courts, the exclusive forum and venue for such action shall be the district courts of Harris County, Texas (unless the parties to the action have agreed otherwise). Per the terms of the plan, you consent to the personal jurisdiction of these courts, as applicable, and waive any objections to personal jurisdiction or inconvenience of the forum and venue specified in this paragraph.

Plan Amendment & Termination

Exxon Mobil Corporation has the right to amend or terminate the Plan at any time. This reservation of the right to amend or terminate benefits applies to benefits for current Eligible Employees and their Eligible Family Members and also to Retirees or terminated employees and their Survivors or Eligible Family Members. Nothing in this document or other communication from the Corporation or its delegee with respect to the Plan shall be deemed to create or imply a continuing obligation by the Corporation to provide or fund benefits to current Eligible Employees or their Eligible Family Members or Survivors, or Retirees or terminated employees or their Eligible Family Members or Survivors.

All amendments to the Plan shall be in writing, and any oral statements or representations made by any individual or entity that purport to alter, modify, amend, or are inconsistent with the written terms of the Plan shall be invalid and unenforceable and may not be relied upon by any individual or entity.

In the event the Plan is terminated, you will have the right to elect continuation coverage, as described in the ,, ,,,,,,,,,,,,,,,,,,section, in any other health plan maintained by ExxonMobil or its controlled group.

Merger or Consolidation

In the event of any dissolution, merger, consolidation, or reorganization of the Corporation in which the Corporation is not the Survivor, the Plan shall terminate with respect to the Corporation and its Eligible Employees unless the Plan is continued by the successor to the Corporation and such successor agrees to be bound by the terms and conditions of the Plan.

Nonalienation of Benefits

No benefit, right, or interest of any Eligible Employee or Eligible Family Member under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities, or other obligations of such person, except as otherwise required by law. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, garnish, execute, or levy upon, or otherwise dispose of any right to benefits payable hereunder shall be void. Notwithstanding the foregoing, the Plan may choose to remit payments directly to health care providers with respect covered services, if authorized by the participant, but only as a convenience to participants. Health care providers are not, and shall not be construed as, either "participants" or "beneficiaries" under this Plan and have no right to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) participants under any circumstances.

Missing Persons

If the Administrator-Benefits, Insurer, or Claims Administrator (as applicable) cannot locate an individual covered under the Plan, after making a reasonably diligent effort, including by giving written notice addressed to the individual's last known address as shown by the records of the Plan, the amount payable to the individual is forfeited, to the extent permitted by applicable law.

Uncashed Checks

If a check to you for benefits under the Plan remains uncashed and you cannot be located after reasonable efforts, such benefits may be forfeited in accordance with the terms of the Plan.

Plan's Right to Recover Overpayments

Payments are made in accordance with the provisions of the Plan, including the Plan Document, this SPD, and the applicable Welfare Program Documents. If it is determined that payment was made for an ineligible charge or that other insurance was considered primary, the Plan has the right to recover the overpayment. The Plan (or any Claims Administrator or Insurer) will attempt to collect the overpayment from the party to whom the payment was made. However, the Plan reserves the right to seek overpayment from any Covered Person. Failure to comply with this request will entitle the Plan to withhold benefits due a Covered Person. In addition, the Plan has the right to engage an outside collection agency to recover overpayments on the Plan's behalf if the Plan's collection effort is not successful.

In addition, if the overpayment is made to an in-network provider, the Plan (or Claims Administrator or Insurer) may reduce or deny benefits, in the amount of the overpayment, for otherwise covered services for current and/or future claims with the in-network provider on behalf of any participant, beneficiary, or dependent in the Plan. If the in-network provider to whom an overpayment was made has patients who are participants in other health and welfare plans administered by the Claims Administrator or Insurer, the Claims Administrator or Insurer may reduce payments otherwise owed to the in-network provider from such other health plans by the amount of the overpayment.

Delegation of Duties

Pursuant to the Plan, the Administrator-Benefits shall have the authority to delegate, from time-to-time, by a written instrument filed in its records or by any other means deemed appropriate by the Administrator-Benefits, all or any part of its responsibilities under the Plan to such person or persons as the Administrator-Benefits may deem advisable (and may authorize such person to delegate such responsibilities to such other person or persons as the Administrator-Benefits shall authorize) and in the same manner to revoke any such delegation of responsibilities. Any action of the delegate in the exercise of such delegated responsibilities (including interpreting Plan terms and serving as a Claims Fiduciary) shall have the same force and effect for all purposes hereunder as if such action had been taken by the Administrator-Benefits. The Administrator-Benefits shall not be liable for any acts or omissions of any such delegate. The delegate shall periodically report to the Administrator-Benefits concerning the discharge of the delegated responsibilities. The Administrator-Benefits will periodically monitor the delegate to verify that the delegation is prudent.

Collective bargaining agreements

Eligibility for participation in the Plan by represented employees is governed by Collective Bargaining Agreements. A copy of the Plan Documents is available for examination upon written request.

No implied promises

Nothing in this SPD or Welfare Program Document says or implies that participation in the Plan or any Welfare Program is a guarantee of continued employment with the Corporation.

Legal Notices

ERISA Rights Statement

As a participant in Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA") with respect to the benefits indicated as covered by ERISA (see the Welfare Programs and Eligibility section). Specifically, ERISA provides that you are entitled to:

Receive Information About Your Plan and Benefits

You may examine, without charge, at the Administrator-Benefits' office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest Annual Report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefit Administration).

You may obtain, upon written request to the Administrator-Benefits, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest Annual Report (Form 5500 Series) and updated SPD, including this ERISA Rights Statement. The Administrator-Benefits may make a reasonable charge for the copies.

You may receive a summary of the Plan's Annual Financial Report. The Administrator-Benefits is required by law to furnish each participant with a copy of this summary.

You may also obtain a statement telling you whether you have a right to receive a pension at normal retirement age and, if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to be eligible for a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, Spouse or Eligible Family Members if there is a loss of coverage under the Plan as a result of a qualifying event as defined under COBRA. You or your Eligible Family Members may have to pay for that coverage. Review the SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including the Corporation, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a 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 Plan documents or the latest Annual Report from the 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-Benefits. If you have a claim for benefits that is 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 Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical support order, you may file suit in Federal court. If it should happen that 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 if, for example, it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Administrator-Benefits. If you have any questions about this ERISA Rights Statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrator-Benefits, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 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.

HIPAA Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses & Disclosures of Your Information

The Plan may use or disclose your PHI for the purposes of routine treatment, payment, or health care operations related to the Plan. For example, the Plan may use your PHI for management activities related to the Plan, including auditing, fraud and abuse detection, and customer service. The Plan also may use or disclose your PHI in order to pay your claims for benefits. For example, the Plan may use your information to make eligibility determinations and for billing and claims management purposes.

Genetic Information Nondiscrimination Act ("GINA")

Note that GINA prohibits using PHI that is genetic information for underwriting purposes.

Plan Sponsor

In addition, the Plan may disclose your PHI to the Plan Sponsor so that the Plan Sponsor can perform administrative functions on behalf of the Plan, such as facilitating claims or appeals.

Exceptions

The Plan also may use or disclose your PHI where required or permitted by law. Federal law, under HIPAA, generally permits health plans to use or disclose PHI for the following purposes:

- where required by law;
- for public health activities;
- to report Child or domestic abuse;
- for governmental oversight activities;
- pursuant to judicial or administrative proceedings;
- for certain law enforcement purposes;
- for a coroner, medical examiner, or funeral director to obtain information about a deceased individual;
- for organ, eye, or tissue donation purposes;
- for certain government-approved research activities;
- to avert a serious threat to an individual's or the public's health or safety;
- for certain government functions, such as related to military service or national security; or
- to comply with Workers' Compensation laws;
- to a family member or close friend that you have identified and who is directly involved in your care or payment for your care; or
- to notify a family member or other individual involved in your care of your location, general condition, or death or to a public or private entity authorized by law or its charter to assist in disaster relief efforts to make such notifications.

Authorization

For any other uses and disclosures of your PHI, the Plan will obtain your written authorization.

Marketing/Sale of PHI and/or Psychotherapy Notes

The Plan will obtain your written authorization to use or disclose PHI for marketing purposes where the Plan receives financial remuneration, for the sale of PHI, or with respect to psychotherapy notes, except for limited health care operations purposes.

Revoke

You may revoke this authorization in writing at any time, provided the Plan has not yet taken action in reliance on your authorization.

Stricter State Privacy Laws

Under HIPAA, the Plan is required to comply with State laws, if any, that also are applicable and are not contrary to HIPAA (for example, where state laws may be stricter). The Plan maintains a policy to ensure compliance with these laws.

Your Rights With Respect To Your Health Information

You have several rights with respect to your PHI, which are described below. Please call the privacy contact listed below if you have questions about your rights.

- You have the right to request restrictions on how your PHI may be used or disclosed. The Plan generally is not required to agree to your requested restriction, except in limited circumstances.
- You have the right to receive your PHI confidentially, such as at a location other than your home, if you state in writing that disclosing the information through normal means could endanger you.
- You have the right to inspect and copy your PHI that is maintained by the Plan in a designated record set or to request an electronic copy. The Plan may charge a reasonable, cost-based fee for such copies.
- You have the right to request an amendment to your PHI that the Plan maintains in a designated record set. The Plan may deny your request for an amendment if it believes your information is accurate and complete, or if the information was created by a party other than the Plan.
- You have a right to request an accounting of disclosures the Plan has made of your PHI for the six years prior to your request, except for disclosures you have authorized or disclosures for routine treatment, payment, or health care operations of the Plan.
- You have a right to request a paper copy of this notice, even if you have agreed to receive this notice electronically.

Our Duties With Respect To Your Individually Identifiable Health Information

The Plan is required by law to maintain the privacy of your PHI and to provide you with a notice of its legal duties and privacy practices with respect to your PHI. The Plan is required to abide by the terms of this notice.

The Plan is required to notify you if there is a breach of your unsecured PHI.

The Plan reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains. If there is a material change to any provisions of this notice, the Plan will distribute a revised privacy notice.

Questions?
If you have questions or would like more information about the Plan's privacy policies, you may contact HIPAA Privacy and Security Contact, ExxonMobil Benefits Service Center - Phone: 833-776-9966, Hours: 8am – 4pm CST, Monday through Friday, except certain holidays.

If you believe your privacy rights have been violated, you may file a complaint with the Plan or the Secretary of the U.S. Department of Health and Human Services. You cannot be retaliated against for filing such a complaint.

Effective Date of Notice: This Notice was revised effective January 1, 2025.

Medicare Prescription Drug Plan Information

Please read this notice carefully. Keep it where you can find it. It contains information about prescription drug coverage under the Plan and your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. You are responsible for providing a copy of this notice to your Medicare eligible family members. Note there is a separate Notice for those participating in the ExxonMobil Retiree Medical Plan ("EMRMP").

Medicare prescription drug coverage (Medicare Part D) is available to everyone enrolled in Medicare. You can get this coverage either by joining a Medicare Part D Plan or a Medicare Advantage Plan that offers prescription drug coverage. (Medicare Advantage Plans are similar to a PPO or HMO, and are also called Medicare Part C.) All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some Medicare Part D and Medicare Advantage plans may also offer more coverage for a higher monthly premium.

If you are actively employed, and become Medicare eligible, you remain eligible to participate in the Plan whether or not you enroll in Medicare. While you are working as an active employee, the Plan remains primary for you and your eligible family members. There is no expectation that you enroll in Medicare Parts A and B until after you are no longer an active employee.

Prescription drug coverage offered by the Plan, on average for all plan participants, is expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. If you participate in the Plan, your coverage is Creditable Coverage and you can keep this coverage and not pay a higher Medicare premium (a penalty) if you later decide to join a Medicare drug plan.

Read this notice carefully. It explains options you have for Medicare prescription drug coverage once you are eligible for Medicare. It can help you decide whether you want to enroll in Medicare prescription drug coverage.

When Can You Join A Medicare Drug Plan?
You can enroll in a Medicare drug plan when you first become eligible for Medicare, and each year thereafter, from October 15 to December 7. However, if you lose Plan prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period ("SEP") to join a Medicare drug plan.

What Happens to Coverage if You Decide to Enroll in a Medicare Drug Plan while you are actively employed?
There is no impact on your Plan benefits if you enroll in a Medicare drug plan so long as you are actively employed.

When Will You Pay a Higher Medicare Premium (Penalty) to Join a Medicare Drug Plan?
You should also know that if you do not join a Medicare drug plan within 63 continuous days of losing coverage under the Plan, EMRMP or any other prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen (19) months without coverage, your Medicare premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher Medicare premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll, since you did not enroll during the SEP.

For More Information about This Notice or Your Current Prescription Drug Coverage
Contact a Service Center Representative at ExxonMobil Benefits Service Center (EMBSC) by calling (833) 776-9966 from Monday through Friday 8 a.m. to 4 p.m. Central Time, except on holidays. Mailing address: Dept 02694, PO Box 64116, The Woodlands, TX, 77387-4116.

NOTE: You will get this notice during the twelve months before you can next enroll in a Medicare drug plan, or if the drug coverage under the Plan or EMRMP changes so that it is not expected to pay out as much as standard Medicare prescription drug coverage pays. You may also request a copy of this notice at any time.

For More Information about Your Options for Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage can be found in the "Medicare & You" handbook. You should get a copy of this handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can get more information about Medicare prescription drug plans by:

Visiting www.medicare.gov

Calling your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486- 2048

Extra help in paying for a Medicare prescription drug plan is available for people with limited income or resources. For more information about this extra help, visit Social Security on the Website at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. A copy may also be printed from the www.exxonmobilfamily.com Web site. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice to show whether or not you have maintained creditable coverage, and therefore, whether or not you are required to pay a higher Medicare premium (a penalty).

2025

ExxonMobil Health and Welfare Plan

ExxonMobil Benefits Service Center

Dept 02694, PO Box 64116

The Woodlands, TX, 77387-4116

Premium Assistance Under Medicaid and the Children's Health Insurance Program ("CHIP")

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 / Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**

Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone:304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor - Employee Benefits Security Administration

www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services - Centers for Medicare & Medicaid Services

www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Women's Health & Cancer Rights Act

Under the Women's Health & Cancer Rights Act of 1998, group health plans covering a mastectomy must also provide coverage for breast reconstruction performed in connection with the mastectomy. Coverage must be provided for:

- Reconstruction of the breast
- Surgery and reconstruction of the breast for symmetrical appearance; and
- Prostheses and physical complications in all stages of mastectomy.

Newborns' Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact the Plan Administrator.

Other Legal Notices

For other legal notices that ExxonMobil is required to provide on an annual basis are part of your Annual Enrollment Period materials, please see Legal Notices on Your Total Rewards portal. In addition, you may also access Summaries of Benefits and Coverage ("SBCs") on the ExxonMobil Benefits Service Center portal.

APPENDIX A

Participating Employers

The following U.S.- based entities (excluding U.S. territories) may participate in one or more Welfare Programs described in the Welfare Programs and Eligibility section of this SPD as of January 1, 2025:

- Wolverine Pipe Line Company
- Station Operators Inc. dba ExxonMobil Company Operated Retail Stores ("CORS")

APPENDIX B

Benefit Booklet Attachments as of January 1, 2025:

a) Medical and Behavioral Health Benefits

b) Prescription Drug Benefits

c) Dental

d) Vision

e) Employee Assistance Program

f) Health Care Flexible Spending Account ("HCFSA")

g) Dependent Care Flexible Spending Account ("DCFSA")

h) Disability Program

i) Life Insurance Program