ExxonMobil Retiree Medical Plan
2025 Wrap Summary Plan Description

ExxonMobil

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Introduction

IF YOU (AND/OR YOUR DEPENDENTS) HAVE MEDICARE OR WILL BECOME ELIGIBLE FOR MEDICARE IN THE NEXT 12 MONTHS, A FEDERAL LAW GIVES YOU MORE CHOICES ABOUT YOUR PRESCRIPTION DRUG COVERAGE. REFER TO THE MEDICARE PRESCRIPTION DRUG PLAN INFORMATION FOR MORE DETAILS.

Overview

The ExxonMobil Retiree Medical 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 Plan is considered a "retiree only" plan under Section 732(a) of ERISA and therefore is not subject to Health Insurance Portability and Accountability Act of 1996 ("HIPAA") portability rules or the insurance market reforms of the Affordable Care Act ("ACA") and the Health Coverage and Education Reconciliation Act and the regulations thereunder.

The Plan consists of the Retiree Medical Plan ("EMRMP") options for Pre-Medicare Retirees (domestic and international coverage options based on country of permanent residential address) and the Primary Option ("MPO") for Medicare-eligible participants. 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 SPD 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.

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.

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

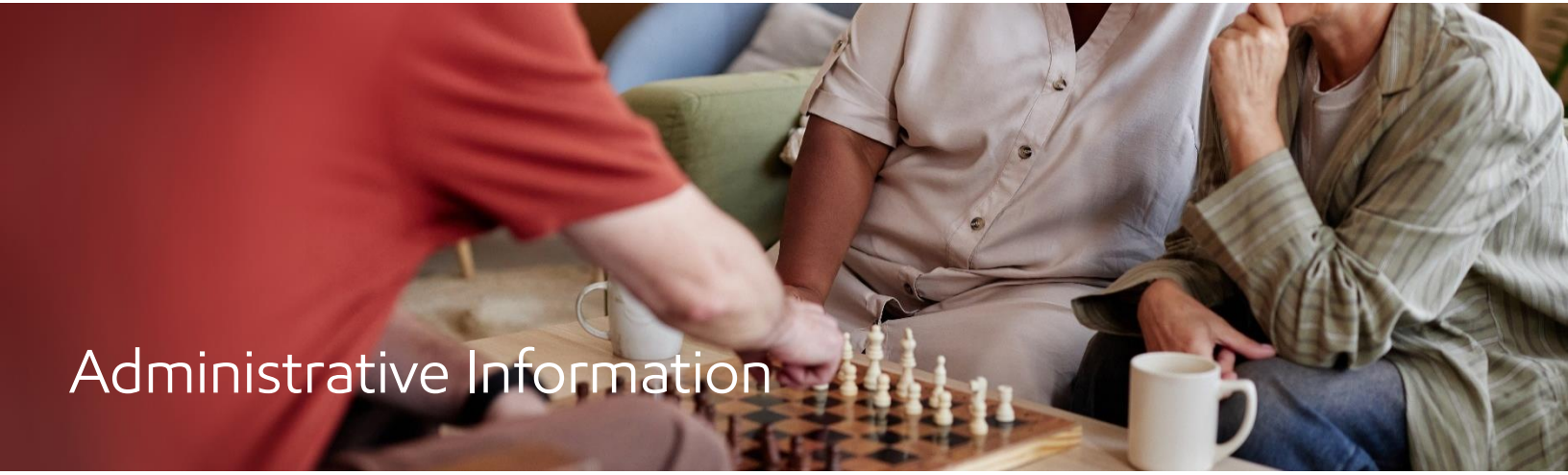
ExxonMobil Business Service Center

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

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

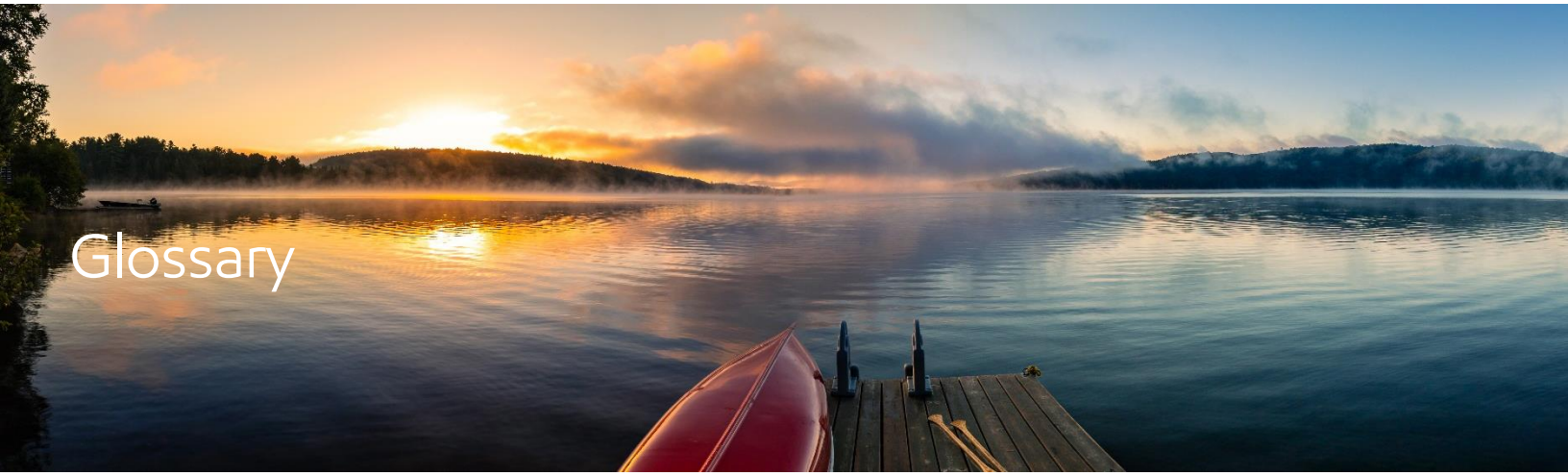
833-776-9966 (8am – 4pm CST, Monday through Friday, except certain holidays)

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



Administrative Information

Plan Name & Number	ExxonMobil Retiree Medical Plan (540)
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 and prescription drug
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 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.

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

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

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.

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

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

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 Retiree, 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 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 Retiree's parents are not eligible to be covered.

Eligible 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 ("LTD") benefits under the ExxonMobil Disability Welfare Program after 15 or more years of benefit service, regardless of age, as long as they continue to meet eligibility requirements under the Disability Welfare Program.

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.

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

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

ExxonMobil Health and Welfare Plan ("EMHWP"): The EMHWP is a health and welfare program sponsored by Exxon Mobil Corporation. Retirees are generally eligible for the following EMHWP Welfare Programs:

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

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.

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.

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: The ExxonMobil Retiree Medical Plan ("Plan") sponsored by Exxon Mobil Corporation which provides medical and prescription drug benefits for Eligible Retirees, Surviving Spouses and their Eligible Family Members, and includes the Pre-65 Retiree Medical Plan ("EMRMP") (domestic and international coverage options) and the Medicare Primary Option ("MPO").

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, to the extent that such Child is an Eligible Family Member under the Plan. A QMCSO must include, at a minimum:

- Name and address of the Eligible Retiree 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.

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 LTD 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.

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 and 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

Domestic Pre-65 Medical, Behavioral Health and Prescription Drug Benefits

Self-funded; Covered by ERISA.

Eligibility

- U.S. Pre-65 Retirees with permanent residential address in the United States;
- Survivor/Surviving Spouse (an Eligible Family Member of a deceased Regular Employee);
- Expatriates with U.S. Company-sponsored green card who retire/retired at the end of a current U.S. assignment on or after July 1, 2020 and remain in the U.S. with a valid green card and waive home country health coverage;
- 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.

NOTE: Pre-65 Retirees who retired on or before December 31, 2022 are covered for both emergent and non-emergent care outside the US. Pre-65 Retirees who retired on or after January 1, 2023 are only eligible for emergent care coverage outside the US.

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 Domestic Pre-65 Health Benefits

Virtual Care Program

Self-funded; Covered by ERISA.

Claims Administrator

MDLive

888 409 8687
Group Number: 1139

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

Second Opinion Services

Self-funded; Covered by ERISA.

Claims Administrator

My Medical Ally

888-361-3944
Company name: ExxonMobil

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

Claims Administrator – Prescription Drug Benefits

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 Appendix B and **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 Appendix B and omadahealth.com/exxonmobil.

International Pre-65 Medical, Behavioral Health and Prescription Drug Benefits

Fully insured; Covered by ERISA.

Eligibility

- U.S. Pre-65 Retirees with permanent residential address outside the United States;
- 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.

NOTE: Pre-65 Retirees who retired on or before December 31, 2022 are covered for both emergent and non-emergent care outside the US. Pre-65 Retirees who retired on or after January 1, 2023 are only eligible for emergent care coverage outside the US.

Insurer – Medical, Behavioral Health and Prescription Drug Benefits

GeoBlue

1-888-412-6403 (within the U.S.) or 1-610-254-5830 (outside the U.S.)

geo-blue.com

For additional details, see Appendix B and [insert GeoBlue website].

Post-65 Medical, Behavioral Health and Prescription Drug Benefits

Eligibility

- U.S. Post-65 Retirees that attained Eligible Retiree status from ExxonMobil, Exxon, Mobil, or Superior Oil Company;
- Expatriates with U.S. Company-sponsored green card who retire/retired at the end of your current U.S. assignment on or after July 1, 2020 and remain in the U.S. with a valid green card and waive home country health coverage;
- Eligible Family Members who are also eligible to be enrolled in Medicare as their primary medical plan include, including
    - The Spouse of an Eligible Retiree; and
    - The Surviving Spouse, who has not remarried, of a deceased Eligible Retiree or deceased Employee.

NOTE: A Child of an Eligible Retiree, deceased Retiree, or deceased Employee is not eligible for coverage under the MPO, with the exception of a grandfathered population of Children who were participating in the ExxonMobil Retiree Medical Plan, Medicare Supplement Plan ("MSP") option on December 31, 2018. The MSP option terminated as of June 30, 2022.

Insurer

Aetna Medicare Primary Option ("MPO")

Fully insured; Covered by ERISA.

For additional details, see Appendix B and ExxonMobil.AetnaMedicare.com.

Claims Administrator – Prescription Drug Benefits

Express Scripts Medicare®

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.

Dental

Self-funded ; Covered by ERISA.

Eligibility

- U.S. Pre-65 and Post-65 Retirees;
- Survivor/Surviving Spouse (an Eligible Family Member of a deceased Regular Employee or Retiree);
- Long-term Expatriates 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.
- 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

The Dental Welfare Program is a component of the ExxonMobil Health and Welfare Plan ("EMHWP"). 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

- U.S. Pre-65 and Post-65 Retirees;
- Survivor/Surviving Spouse (an Eligible Family Member of a deceased Regular Employee or Retiree);
- Long-term Expatriates 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;
- 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

Metropolitan Life Insurance Company

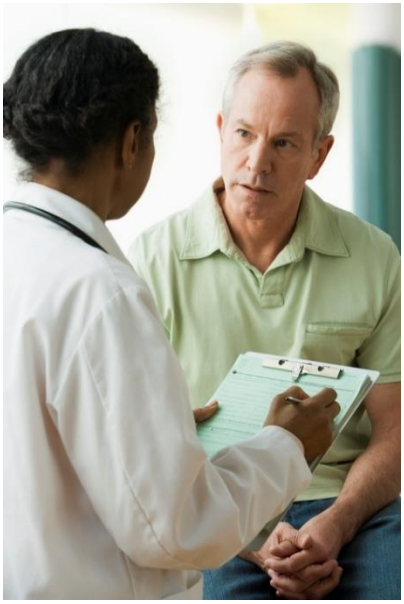
700 Quaker Lane - 2nd Floor - Warwick, RI 02886
1-833-EYE-LIFE
Policy Number: 191000-1-G

The Vision Welfare Program is a component of the EMHWP. For additional details, see Appendix B and metlife.com/info/exxonmobil (goto/metlifevision from a device issued by the Corporation)

Disability Benefits

Long-term Disability ("LTD")

Self-Funded; Covered by ERISA



Eligibility

- Retirees who separated from the Corporation while on LTD with 15 or more years of service will continue to receive LTD benefits as long as they meet the eligibility requirements as described under the Disability Welfare Program.

Claims Administrator

Alight

alight

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

The Disability Welfare Program is a component of the EMHWP. For additional details, see Appendix B.

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

Basic Life Insurance

Self-Funded; Covered by ERISA.

Eligibility

- 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.

Basic Life Insurance is part of the Life Insurance Program, which is a component of the EMHWP. 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. For additional details, see Appendix B.

Insurer

cigna healthcare

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.

Group Universal Life ("GUL") Insurance

Self-Funded; Covered by ERISA.

Eligibility

- Retirees who have retired on or before December 1, 2015, may choose coverage equal to a maximum of five times their annualized monthly benefit pay, up to age 70; and
- Retirees who have retired after December 1, 2015, can continue Group Life Insurance coverage after retirement under the ExxonMobil Life Insurance Program until age 95.

Insurer

MetLife

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

GUL is part of the Life Insurance Program, which is a component of the EMHWP. For additional details, see Appendix B.

EMRMP Enrollment and Participation

There are domestic and international coverage options available to Pre-65 retirees under the EMRMP.

How to enroll in the EMRMP

Pre-65 Retirees have three opportunities to enroll:

1. At retirement, or
2. If you have waived coverage (see Other Employer Sponsored Coverage – Waiving Plan) and later lose coverage under another employer coverage.

There is no opportunity to enroll yourself in the Plan at any other time, including during Annual Enrollment. Retirees cannot enroll in health benefits or add Eligible Family Members during Annual Enrollment. Eligible Family Members can only be added to your coverage at one of the enrollment opportunities listed above or if you experience a corresponding change in status.

Do not wait to remove a family member who loses eligibility; they should be removed as soon as eligibility is lost at the time of loss of eligibility and not at Annual Enrollment.

If you do not want to make any changes, you don't have to do anything during Annual Enrollment to continue with your current plan selection for the following year.

You must complete the forms required for payment of contributions within 60 days of enrollment in the Plan. If you fail to do so, coverage will be retroactively suspended and you will be prevented from enrolling at a future date until you pay past contributions.

You can enroll either online or by phone.

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

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

enroll family members who are not eligible for the Plan, for instance, by covering Children who do not meet the eligibility requirements, you may lose eligibility for yourself and your family under all ExxonMobil health plans.

You may cancel your coverage at any time; however, you may not re-enroll unless you experience a corresponding change in status or you wait until one of the enrollment opportunities listed above. Coverage will be terminated at the end of the month in which your elected change has been received.

Eligible Family Members may also be removed from your coverage at any time; however, they may not be reinstated unless you experience a corresponding change in status or you wait until one of the enrollment opportunities listed above.

Note: You are required to remove family members who are no longer eligible for coverage at the time of loss of eligibility. To remove an ineligible family member (a divorced Spouse for example) you are required to notify the Benefits Service Center within 60 days of the loss of eligibility or your ineligible family members will not be entitled to COBRA benefits continuation. If you fail to notify the Benefits Service Center, you may also lose eligibility for yourself and your family under all ExxonMobil health plans. In addition, you will be required to reimburse the Plans for any claims paid after the loss of eligibility for any ineligible person(s).

Dual Coverage

No one can be covered more than once in the EMRMP. You and an Eligible Family Member cannot both enroll as Eligible Retirees and elect coverage for each other as Eligible Family Members. If you and your Spouse or adult Child are both Retirees you may both be eligible for coverage. Each of you can be covered as an individual Retiree, or one of you can be covered as the Retiree 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.

Classes of coverage

You can choose coverage as a:

- Individual only (Retiree, Surviving Spouse, Surviving Child),
- Retiree and Spouse,
- Individual and Child(ren), or
- Family.

Each class of coverage described in this section has its own contribution rate. Retirees and Survivors receiving monthly benefit checks from ExxonMobil pay by deductions from these checks on an after-tax basis. Other Eligible Retirees or Survivors and participants with continuation coverage pay by check or by monthly draft on their bank account.

When your EMRMP coverage ends

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

The last day of the month in which:

- You die,
- You elect not to participate,
- A family member ceases to be eligible (for example, a Child reaches age 26),
- You become a Suspended Retiree,
- You are no longer eligible for benefits under this Plan (e.g. as a Surviving Spouse, you re-marry),

- You, as an Eligible Retiree, or your Eligible Family Member becomes eligible for Medicare and for the MPO;
- Your former employer discontinues participation in the Plan,

OR

The effective date:

- You do not make any required contribution,
- You are rehired by ExxonMobil after retirement as an Employee or Non-regular Employee,
- 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.

For retirees that become eligible for Medicare, please see How to Enroll in the MPO for MPO enrollment requirements. If you do not timely comply with the MPO enrollment requirements, you will remain covered under the EMRMP for a period not to exceed 3 months after your retirement month or the month in which you turn 65. If appropriate action is not take during this 3-month period, coverage for you and your Eligible Family Members will be terminated when the applicable 3 month period expires.

You are responsible for ending coverage with the Benefits Service Center when your enrolled Spouse or family member is no longer eligible for coverage. To end coverage for your Spouse or family member when no longer eligible, contact the ExxonMobil Benefits Service Center. If you do not complete your change within 60 days, any contributions you make for ineligible family members will not be refunded.

Under some circumstances, 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].

MPO - Enrollment and Participation

How to enroll in the MPO

There is only one class of coverage under the MPO – Individual only. There are several conditions for eligibility for the MPO. You must:

- Be an Eligible Retiree or Eligible Family Member;
- Be enrolled in Medicare Parts A and B and continue to pay any required premiums;
- Provide a Medicare Beneficiary Identifier ("MBI"), located on your Medicare card to ExxonMobil Benefits Service Center;
- Have a residential U.S. street address on file with Centers for Medicare & Medicaid Services ("CMS");
- Not be enrolled in another group or individual Medicare Advantage plan (Part C);
- Not be enrolled in an individual Medicare Part D prescription drug plan in the open market (Part D).

Retirees have three opportunities to enroll in the in the ExxonMobil Retiree Medical Plan:

- At retirement, or
- If you have waived coverage (see Other Employer Sponsored Coverage – Waiving Plan) and later lose coverage under another employer coverage, or
- When first eligible to be enrolled in Medicare as your primary plan.

There is no opportunity to enroll yourself in the MPO at any other time, including during Annual Enrollment. If you are 65 or older at the time of your retirement or you are about to turn 65 while participating in the EMRMP option, and have other employer coverage, you must waive coverage to maintain eligibility (please refer to the Other Employer Sponsored coverage - Waiving Plan section).

Eligible Spouses may be added to your coverage at one of the three enrollment opportunities listed above or if you experience a change in status. Eligible Spouses cannot be added to your coverage at any other time, including during Annual Enrollment.

Eligible Retirees and their Spouses and Surviving Spouses will be contacted shortly before their 65th birthdays. If you have not been contacted by the time you become eligible for Medicare, contact the ExxonMobil Business Service Center at 1-833-776-9966. This is particularly important if you or your spouse become eligible for Medicare by virtue of disability rather than age. Your enrollment in the MPO is subject to your Medicare Parts A & B effective date that occurs the first of the month in which you turn age 65 (if your birthday is on the first of the month, coverage begins the first of the prior month prior), providing an MBI, providing a U.S. residential address, not be enrolled in other individual or group Medicare Part C, or individual Medicare Part D prescription drug plan in the open market. However, if you do not comply with the requirements listed above by the effective date, you will remain covered under your current medical plan option for a period not exceeding 3 months after your retirement month or the month in which you turn 65.

When you receive your MBI red, white, and blue ID card, contact the ExxonMobil Business Service Center at 1-833-776-9966 and provide your Medicare information to complete your enrollment under the MPO. You'll first receive a letter confirming your MPO effective date of coverage, followed by your Medicare ID card.

If you do not enroll in Medicare Parts A and B and provide your MBI (located on your Medicare card) to the ExxonMobil Business Service Center by the end of the third month following either the month you turn age 65 or the month you retire, you and any Eligible Family Members will lose coverage under the Plan and you will not have an opportunity to re-enroll at a later date, unless you waive coverage.

When your MPO coverage ends

Generally, MPO coverage for you and/or your Eligible Family Members ends:

- When a participant fails to make the required contributions to the MPO (see section Cancellation and Reinstatement Process for more information) or Medicare Parts A or B.
- When you cancel your coverage in writing.
- For a Spouse following a divorce.
- For a Surviving Spouse and stepchildren upon remarriage (all coverage ends under the Plan).
- For Children (Children that were part of the MSP by December 31, 2018; this option terminated as of June 30, 2022) upon the marriage of a parent who is a Surviving Spouse.
- For the Surviving Spouse and Children (Children that were part of the MSP by December 31, 2018; this option terminated as of June 30, 2022) of an employee who died with less than 15 years of ExxonMobil service after a period from the date of death equal to twice the deceased Retiree's length of ExxonMobil benefit service.
- If, at some future date, the MPO is terminated or replaced.

If you cancel your coverage or did not properly waive coverage, you will not be allowed to re-enroll in the future. Also, if you are not covered under this or another medical plan to which ExxonMobil contributes, your otherwise Eligible Family Members cannot continue coverage under any ExxonMobil medical plans.

Post-Retirement Mid-Year Change in Status

The following describes all the change in status events that allow changes in status post-retirement that apply to the Plan. 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.

Qualified change in status	You are required/permitted to
Both EMRMP and MPO	
Marriage	Add your Spouse and any new Eligible Family Members to the applicable Plan option.
Divorce – Retiree and Spouse enrolled in ExxonMobil health plans	You are required to remove coverage for your former Spouse and any stepchild (ren).
Divorce – Retiree loses coverage under Spouse's health plans	Enroll yourself and add other Eligible Family Members who might have lost eligibility for Spouse's plan to the applicable Plan option.
Gain an Eligible Family Member through birth, adoption or placement for adoption, sole court appointed legal guardian, or sole managing conservator	Add new Eligible Family Members to the applicable Plan option.
Death of a Spouse	You must remove coverage for any stepchild(ren) unless you are their court appointed legal guardian or sole managing conservator.
If you have waived coverage and you or an Eligible Family Member loses eligibility under another employer's group health plan	Enroll yourself and add Eligible Family Members subject to the applicable waiver.
You lose eligibility in a Plan option because of a change in your employment status, e.g., Retiree to rehired Employee.	Your Plan participation will automatically be suspended at the date of rehire and you will be covered under the Plan.
You or your Spouse become entitled to enroll in Medicare as your primary plan	You or your Spouse lose eligibility under the EMRMP options but may enroll in the MPO

Your disabled Child becomes entitled to enroll in Medicare as their primary plan, even if your Child is not actually enrolled in Medicare	You must remove coverage for your Child.
Judgment, decree, or other court order requiring you to cover an Eligible Family Member. (e.g. begin a QMCSO)	Add new Eligible Family Members.
You change your U.S. residential address to a Non-US address affecting your eligibility to participate in a Plan option	For EMRMP, Retirees and their Eligible Family Members will be enrolled in GeoBlue. If/when they return, Retirees and their Eligible Family Members will be moved to the available domestic Pre-65 Plan options. For MPO, you must remove yourself and all Eligible Family Members from the Plan.
EMRMP Only	
You gain eligibility in the EMRMP because of a change in your employment status, e.g., Employee to Retiree.	Enroll yourself and add Eligible Family Members in the EMRMP.

Other situations that may affect EMRMP coverage only

Change in coverage costs or significant curtailment

If the cost for coverage charged to you significantly increases or decreases during a Plan Year, you may be able to make a corresponding prospective change in your election, including the cancellation of your election. If you choose to cancel your elected coverage option, you may be able to elect coverage under another EMRMP option or to cancel medical coverage altogether if no similar option is available.

This provision also applies to a significant increase in plan option deductible or copayment.

If the cost for coverage under your Spouse's medical plan significantly increases or there is a significant curtailment of coverage that permits revocation of coverage during a Plan Year and you drop that coverage, you will be able to sign up for EMRMP coverage for yourself and your Eligible Family Members.

Addition or improvement of plan options

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

Loss of option

If a service area under the Plan is discontinued, you will be able to elect either to receive coverage under another EMRMP option providing similar coverage or to cancel 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. You may also cancel medical coverage altogether.

If a covered family member lives away from home

Coverage depends on whether the option you are enrolled in as an Eligible Retiree offers service in the area where you live.

If you or your covered Spouse become eligible for Medicare

If you are an Eligible Retiree, you and your Eligible Family Members who are not eligible for Medicare participate in the EMRMP. When you (as a Retiree) or a covered Spouse of an Eligible Retiree becomes eligible for Medicare as your primary plan, you or your Spouse will no longer be eligible for the EMRMP, but you or your Spouse may be eligible to enroll in the MPO. If you fail to enroll in the MPO when first eligible, then you or your covered Spouse will not be able to enroll at a later time without proof of properly waiving coverage and of having other employer provided medical coverage immediately prior to enrollment.

If you die

If you die while enrolled, your covered Eligible Family Members can continue coverage through the EMRMP. Eligibility continues for your Spouse until your Spouse remarries, or becomes eligible for Medicare. Upon eligibility for Medicare as their primary plan, your Spouse can continue coverage through the MPO.

Children of deceased Employees or Retirees may continue participation in the EMRMP as long as they are an Eligible Family Member and are not eligible to be enrolled in Medicare as their primary plan. If your Surviving Spouse remarries, eligibility for your stepchildren also ends. Special rules may apply to family members of individuals who become Retirees due to disability. See Suspended Retiree below.

If you become a Suspended Retiree

If you are an Eligible Retiree and you would otherwise lose coverage because you have become a Suspended Retiree under the ExxonMobil Disability Welfare Program, you may continue coverage for yourself and all your Eligible Family Members who were eligible for EMRMP participation before you became a Suspended Retiree for either 12 or 18 months.

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

Other situations that may affect all Plan coverages

Other Employer Sponsored coverage – Waiving Coverage

A waiver process is in place to provide Eligible Retirees and Eligible Family Members with the option to waive coverage under the Plan when you or your Eligible Family Members choose to participate in other employer-sponsored coverage. By completing the waiver, you will reserve your right to participate in the Plan at a later date upon proof of loss of coverage in the other employer's plan, as long as the Plan is still available at that time. See scenarios below and how the waiver and reservation of rights apply.

How to Waive Plan Coverage at the Time of Your Retirement

If you have been actively participating in the EMHWP or the ExxonMobil International Medical and Dental Plan at the time of your retirement and you have access to other employer-sponsored coverage through either your own active employment or as a dependent of your Spouse's active employment, you/your Spouse can choose to waive coverage and reserve your right to participate upon the loss of such other coverage.

You must waive coverage no later than 60 days from your retirement effective date. There are 2 ways to waive:

- You can contact the ExxonMobil Benefits Service Center at 1-833-776-9966 and indicate you want to waive, or
- You may also waive online in the Your Total Rewards portal by choosing the qualifying event named "Other Employer Sponsored Coverage".

In order to enroll at a later date, you and/or your Spouse will need to provide proof of loss of coverage and meet the following requirements:

- If you (and/or your Spouse) lose other employer-provided coverage and you or your Spouse are under 65 years of age, you have 60 days from loss of coverage to enroll in any of the Plan options.
- If you (and/or your Spouse) lose coverage and are 65 years of age or over, you or your Spouse will have 90 days from loss of coverage to enroll in the Plan. Please refer to section Enrollment and Participation section of the SPD for a list of the MPO requirements. You must meet each of the requirements within the 90 days from the loss of coverage.

If you do not meet all requirements to enroll in the applicable option by the deadlines above, you/your Spouse will not be eligible to enroll in the Plan at a later date.

How to Waive Plan Coverage if you Acquire Other Employer-Sponsored Coverage After Retirement

If after you have begun participating in the Plan you acquire other employer sponsored health plan coverage through either your own active employment or as a dependent of your Spouse's active employment, you/your Spouse can notify the Plan by contacting the ExxonMobil Benefits Service Center of your change in status and waive coverage under the Plan.

There are 2 ways to waive:

- You can contact the ExxonMobil Benefits Service Center at 1-833-776-9966 and indicate you want to waive, or
- You may also waive online in the Your Total Rewards portal by choosing the qualifying event named "Other Employer Sponsored Coverage".

You must waive no later than 60 days from loss of coverage from the Plan.

You/your Spouse can then enroll in the Plan at a later date when the other employer sponsored health plan ends, with proof of loss of coverage.

Important note: A waiver form is different from a cancellation form, while the waiver form allows you to preserve your eligibility for future enrollment (if the Plan is still an available option at that time), the cancellation form is final and you will no longer be eligible to enroll in any of the Plan options at a later date.

Dependent Children

If your Child is participating in other-employer sponsored coverage at the time of your retirement or during your retirement and the Child is under the age of 26, this Child will be eligible upon the proof of loss of coverage to participate in the Plan and no waiver form is needed, assuming the Child meets eligibility criteria.

No waiver process is available for dependents who were participating the EMHWP or Plan as a disabled dependent over the age of 26 and who terminate coverage anytime at or after your retirement. Once a disabled Child's coverage is terminated for loss of eligibility or otherwise, the over age 26 Child will not be eligible to participate in the Plan at a later date.

Survivor Coverage

If you are a Surviving Spouse or Surviving Family Member participating in the Plan, you are not eligible to waive coverage and reserve your right to participate at a later date when you acquire other employer-sponsored coverage or are hired by ExxonMobil.

Funding of Benefits

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 Retiree premiums and contributions. 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 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 Retiree contributions to pay benefits directly to or on behalf of you and your Eligible Family Members from the Corporation's general assets.

Retiree 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.

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.

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

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 have missed payments, contact the ExxonMobil Benefits Service Center immediately for guidance in order to regularize your situation.

The cancellation and reinstatement process 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.

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.

COBRA Continuation

Generally, EMEMRMP benefits subject to COBRA include medical, prescription drug, dental, and vision. Eligible Retirees and Eligible Family Members will be offered the same medical, prescription drug, dental, and vision coverage that you had the day before the qualifying event that caused you to lose coverage under the Plan.

Cost of COBRA Continuation Coverage

The cost of COBRA continuation coverage will be the full cost of coverage plus a 2% administrative fee. When you enroll, you will receive a separate notice that gives you more information on your COBRA rights. You will also receive an election notice if you experience a qualifying event. For more information, please contact the Plan's COBRA administrator.

When Your Eligible Family Members May Elect COBRA Coverage

Your Eligible Family Members may elect to continue coverage for up to 36 months if coverage ends for one of the following reasons:

- Your death;
- Your divorce or legal separation;
- Your eligibility for Medicare during a COBRA continuation period; or
- If your covered child no longer meets the eligibility requirements under the Plan.

If you or your Eligible Family Members are determined to be disabled (for Social Security benefit purposes) when your coverage ends, or within the first 60 days of COBRA coverage, coverage for your entire family may continue for a total of 29 months.

Applying for COBRA Coverage

When your coverage ends, you or your Eligible Family Members have 60 days to elect continued coverage. The 60 days is counted from the day your active benefits end or the date of your COBRA notice is mailed, whichever is later.

In the case of losing coverage on account of a divorce, legal separation, or when a child no longer qualifies for dependent coverage, you or your Eligible Family Members must notify the COBRA administrator within 60 days. Your Eligible Family Members will not be eligible for COBRA coverage unless you notify the COBRA administrator that they have lost eligibility for coverage.

When COBRA Coverage Ends

COBRA coverage will end if:

- The Company stops providing coverage for all employees (including former employees);
- You or your Eligible Family Members do not pay your premiums on time;
- You or your Eligible Family Members become covered by another group health plan;
- You or your Eligible Family Members become covered by Medicare; or
- You or your Eligible Family Members extended COBRA coverage to 29 months due to disability, but no longer consider disabled.

Continuing Coverage for Eligible Family Members of Deceased Retired Employees

If you are the Eligible Family Member of a deceased Eligible Retiree, you are eligible to continue coverage in the Program if you were covered by the Program immediately before the death of the Eligible Retiree. There can be no gap in coverage. While you remain covered by the Program your benefits and required contribution will remain the same as for others in the Program.

As the Spouse of a deceased Eligible Retiree, your coverage terminates on the first day of the first month following the date you remarry. As the Child of a deceased Eligible Retiree, your coverage terminates when you no longer satisfy the definition of a Child pursuant to the terms of the Program.

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 Retiree Medical 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 Welfare Programs and Eligibility section. Self-funded benefits will be decided by the Claims Administrator listed in the 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, 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.

LTD Claims	
Claim Types	**Timing**
Initial Claim	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.

All Other Benefits	
Claim Types	**Timing**
Initial Claim	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.

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, 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**
Mandatory Appeal	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 All Other Benefits	
Claim Types	**Timing**
Mandatory Appeal	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.

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.

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 with Other Plans

The Plan has the right to coordinate its payment of medical, dental or vision benefits with any "other health plan" under which you or your Eligible Family Members are covered. Unless otherwise specified in the applicable Welfare Program, the Plan will coordinate benefits with any other group health plan, including Medicare Parts A and B, that covers you or your Eligible Family Members under the rules below.

The total medical, dental or vision benefits paid by the Plan together with other plans will not exceed the level of benefits that would otherwise be paid by the Plan. These rights may be described in the applicable Welfare Program Document. If the applicable Welfare Program Document does not include a description of these rights, the Plan will coordinate benefits with the "other plan."

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

- other employer group health plan coverage (including other retiree medical 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. A plan without a coordination of benefits provision will always be the primary payer. The Plan has a coordination of benefits provision.

Order of Benefit Determination

If all plans have a coordination of benefits provision, the following will apply:

1. 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.
2. If both plans cover a dependent, the plan of the enrollee whose birthday occurs earlier in the calendar year is the primary plan.
3. 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;
4. 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.
5. 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. With respect to no-fault coverage, personal injury protection, and medical payment coverage, the Plan is always secondary. This provision shall permit the Plan to pay first and then seek reimbursement in the case of no-fault coverage. 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.

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 Administrator – Benefits 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.

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.

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.

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

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE UNDER THE EXXONMOBIL RETIREE MEDICAL PLAN AND MEDICARE

Please read this notice carefully. Keep it where you can find it. It contains information about prescription drug coverage under the ExxonMobil Retiree Medical Plan ("EMEMRMP") and your options under Medicare's prescription drug coverage. This letter applies to the 2025 Plan Year and the pre-65 Retiree Medical Plan ("EMRMP") options and the Medicare Primary Option ("MPO"). 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.

Medicare prescription drug coverage (Medicare Part D) is available to everyone with 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 a Retiree or Survivor, and become Medicare eligible, you are no longer eligible for these options under the EMRMP are expected to enroll in Medicare Parts A and B and move to the MPO as soon as you are eligible. Note that Medicare eligibility may be acquired on account of age or because of disability status under Social Security.

Prescription drug coverage offered by the EMRMP, 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 EMRMP, your coverage is Creditable Coverage, and you can keep this coverage and not pay a higher Medicare premium (a penalty) should you decide later to join a Medicare drug plan.

The MPO option is an employer group Medicare Part C arrangement that also includes self-insured prescription drug coverage. Coverage under the MPO is considered Creditable Coverage.

Read this notice carefully. It explains options you have for Medicare prescription drug coverage. 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 EMEMRMP 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 Your Coverage If You Decide to Enroll in a Medicare Drug Plan?

If you enroll in either another Medicare Part D, or another Medicare Advantage (Part C) plan (not the MPO) that includes drug coverage, your coverage under the MPO will end even if you do not cancel or drop your MPO coverage. For those participating in the MPO, you may only be enrolled in a group Medicare Part D, also referred to as Employer Group Waiver Plan ("EGWP") if a former employer enrolls you.

If you cancel or drop your EMEMRMP coverage, be aware that you will not be able to reenroll in the EMEMRMP at any later time, even for coverage for health expenses other than prescription drugs. You should compare your current coverage provided under the EMEMRMP, including which drugs are covered, with the coverage and cost of plans offering Medicare prescription drug coverage in your area before you make the decision to drop your coverage.

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 EMEMRMP 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 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 EMEMRMP 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 Website. 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 Retiree Medical Plan Service Center / ExxonMobil Benefits Service Center

Dept 02694, PO Box 64116,

The Woodlands, TX, 77387-4116

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 (including applicable Non-Discrimination Notices), 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.

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 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 Retirees or terminated Employees and their Survivors or Eligible Family Members.

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 COBRA Continuation 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 Retirees 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.

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
  - Self-insured medical benefits and prescription drug benefits

APPENDIX B

Benefit Booklet Attachments as of January 1, 2025:

a) EMRMP Medical and Behavioral Health Benefits

b) EMRMP Express Scripts Prescription Drug Benefits

c) Dental

d) Vision

i) Basic Life Insurance Program

j) MPO Medical and Behavioral Health Benefits

k) MPO Express Scripts Medicare® Prescription Drug Benefits