Blue Cross Blue Shield Global – ExxonMobil Retiree Medical Plan – GeoBlue Option A

Pre-65 options for retirees who have a permanent residential address outside the United States effective January 1, 2025

00111961

GeoBlue Option A Benefit Highlights	International You Pay	U.S. Participating Provider You Pay	U.S. Non-Participating Provider You Pay
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Annual Deductible			
Individual	$800	$600	$800
Family	$1,600	$1,200	$1,600
Annual Out-of-Pocket Maximum			
Individual	$9,100	$7,000	$15,000
Family	$18,200	$14,000	$30,000
The following expenses contribute to the Out-of-Pocket Maximum: Copayments; Plan Deductible; Prescription Drug Copayments; Coinsurance			
Accumulation of Plan Deductibles and Out-of-Pocket Maximums Deductibles and Out-of-Pocket Maximums will cross-accumulate between U.S. Participating Provider, U.S. Non-Participating Provider and International. All other Plan maximums and service-specific maximums (dollar and occurrence) will also cross-accumulate.			
Preventive Care			
Routine Preventive Care	$0	$0	$0
Immunizations	$0	$0	$0
Office Visits			
Primary Care Physician	45% after deductible	$40 copay, not subject to deductible	45% after deductible
Specialist	45% after deductible	$60 copay, not subject to deductible	45% after deductible
Travel Immunizations	0%	0%	0%
Acupuncture or Acupressure Annual Maximum of 20 visit limit.	45% after deductible	$60 copay, not subject to deductible	45% after deductible
Chiropractic Care/Spinal Manipulations Annual Maximum of 20 visit limit.	45% after deductible	$60 copay, not subject to deductible	45% after deductible
Habilitative and Rehabilitative Therapy Annual Maximum of 60 visit limit for all therapies combined.	45% after deductible	$60 copay, not subject to deductible	45% after deductible
Hearing Benefit One Examination per calendar year.	45% after deductible	$60 copay, not subject to deductible	45% after deductible
Hearing Aid Benefit Payable as any other covered service. Every 36 months for each covered person. State specific limitations or mandates may apply.	45% after deductible	25% after deductible	45% after deductible

Benefit Summary

GeoBlue Option A Benefit Highlights	International You Pay	U.S. Participating Provider You Pay	U.S. Non-Participating Provider You Pay
Pediatric Hearing Aid and Cochlear Implant	45% after deductible	25% after deductible	45% after deductible
Urgent Care Center	45% after deductible	$60 copay, not subject to deductible	45% after deductible
Pre-Hospital Emergency Medical Services (Ambulance Services)	25% after deductible	25% after deductible	25% after deductible
Emergency Ambulance Services	25% after deductible	25% after deductible	25% after deductible
Non-Emergency Ambulance Services Preauthorization Required.	45% after deductible	25% after deductible	45% after deductible
Emergency Department Copayment waived if admitted to Hospital.	$150 copay + 25% after deductible	$150 copay + 25% after deductible	$150 copay + 25% after deductible
Non - Emergency Use of the Emergency Department Copayment waived if admitted to Hospital.	$150 copay + 45% after deductible	$150 copay + 25% after deductible	$150 copay + 45% after deductible
Inpatient Hospital – Facility/Professional Charges	$500 copay per admission + 45% after deductible	$300 copay per admission + 25% after deductible	$500 copay per admission + 45% after deductible
Laboratory and Radiology Services	45% after deductible	25% after deductible	45% after deductible
Maternity Care/Obstetrical Services	45% after deductible	25% after deductible	45% after deductible
Infertility Expenses – Basic Covered Expenses include Charges made by a Physician to diagnose and to surgically treat the underlying medical cause of infertility.	45% after deductible	25% after deductible	45% after deductible
Infertility Expenses – Comprehensive State specific mandates may apply.	Not covered	Not covered	Not covered

GeoBlue Option A
Prescription Drugs – Retail and Mail Order
Copayments based on a one (1) month supply
*Prior authorization may be required

	Outside of the United States You Pay	Inside of the United States	
		Participating Retail Pharmacy You Pay	Non-Participating Retail Pharmacy You Pay
Tier 1 Prescription Drugs Generic*	40% per prescription or refill after deductible	30% per prescription or refill. Deductible does not apply. The maximum copay per 1 month supply is $60.	40% per prescription or refill after deductible
Tier 2 Prescription Drugs Preferred brand*	40% per prescription or refill after deductible	30% per prescription or refill. Deductible does not apply. The maximum copay per 1 month supply is $130.	40% per prescription or refill after deductible
Tier 3 Prescription Drugs Non-preferred brand*	50% per prescription or refill after deductible	50% per prescription or refill. Deductible does not apply. The maximum copay per 1 month supply is $200.	50% per prescription or refill after deductible
Tier 4 Specialty Drugs*	50% per prescription or refill after deductible	50% per prescription or refill. Deductible does not apply. The maximum copay per 1 month supply is $400.	50% per prescription or refill after deductible

Blue Cross Blue Shield Global – ExxonMobil Retiree Medical Plan – GeoBlue Option B

Pre-65 options for retirees who have a permanent residential address outside the United States effective January 1, 2025

00111962

GeoBlue Option B Benefit Highlights	International You Pay	U.S. Participating Provider You Pay	U.S. Non-Participating Provider You Pay
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Annual Medical Deductible			
Individual	$700	$400	$700
Family Maximum	$1,400	$800	$1,400
Annual Out-of-Pocket Maximum			
Individual	$9,100	$5,500	$15,000
Family Maximum	$18,200	$11,000	$30,000
The following expenses contribute to the Out-of-Pocket Maximum: Copayments; Plan Deductible; Prescription Drug Copayments; Coinsurance			
Accumulation of Plan Deductibles and Out-of-Pocket Maximums Deductibles and Out-of-Pocket Maximums will cross-accumulate between U.S. Participating Provider, U.S. Non-Participating Provider and International. All other Plan maximums and service-specific maximums (dollar and occurrence) will also cross-accumulate.			
Preventive Care			
Routine Preventive Care	$0	$0	$0
Immunizations	$0	$0	$0
Office Visit			
Primary Care Physician	40% after deductible	$25 copay, not subject to deductible	40% after deductible
Specialist	40% after deductible	$45 copay, not subject to deductible	40% after deductible
Travel Immunizations	0%	0%	0%
Acupuncture or Acupressure Annual Maximum of 20 visit limit.	40% after deductible	$45 copay, not subject to deductible	40% after deductible
Chiropractic Care/Spinal Manipulations Annual Maximum of 20 visit limit.	40% after deductible	$45 copay, not subject to deductible	40% after deductible
Habilitative and Rehabilitative Therapy Annual Maximum of 60 visit limit for all therapies combined.	40% after deductible	$45 copay, not subject to deductible	40% after deductible
Hearing Benefit One Examination per calendar year.	40% after deductible	$45 copay, not subject to deductible	40% after deductible
Hearing Aid Benefit Payable as any other covered service. Every 36 months for each covered person. State specific limitations or mandates may apply.	40% after deductible	20% after deductible	40% after deductible

Benefit Summary

GeoBlue Option B Benefit Highlights	International You Pay	U.S. Participating Provider You Pay	U.S. Non-Participating Provider You Pay
Pediatric Hearing Aid and Cochlear Implant	40% after deductible	20% after deductible	40% after deductible
Urgent Care Center	40% after deductible	$45 copay, not subject to deductible	40% after deductible
Pre-Hospital Emergency Medical Services (Ambulance Services)	20% after deductible	20% after deductible	20% after deductible
Emergency Ambulance Services	20% after deductible	20% after deductible	20% after deductible
Non-Emergency Ambulance Services Preauthorization Required.	40% after deductible	20% after deductible	40% after deductible
Emergency Department Copayment waived if admitted to Hospital.	$150 copay + 20% after deductible	$150 copay + 20% after deductible	$150 copay + 20% after deductible
Non - Emergency Use of the Emergency Department Copayment waived if admitted to Hospital.	$150 copay + 40% after deductible	$150 copay + 20% after deductible	$150 copay + 40% after deductible
Inpatient Hospital – Facility/Professional Charges	$400 copay per admission + 40% after deductible	$200 copay per admission + 20% after deductible	$400 copay per admission + 40% after deductible
Laboratory and Radiology Services	40% after deductible	20% after deductible	40% after deductible
Maternity Care/Obstetrical Services	40% after deductible	20% after deductible	40% after deductible
Infertility Expenses – Basic Covered Expenses include Charges made by a Physician to diagnose and to surgically treat the underlying medical cause of infertility.	40% after deductible	20% after deductible	40% after deductible
Infertility Expenses – Comprehensive State specific mandates may apply.	Not covered	Not covered	Not covered

GeoBlue Option B
Prescription Drugs – Retail and Mail Order
Copayments based on a one (1) month supply
*Prior authorization may be required

	Outside of the United States You Pay	Inside of the United States	
		Participating Retail Pharmacy You Pay	Non-Participating Retail Pharmacy You Pay
Tier 1 Prescription Drugs Generic*	40% per prescription or refill after deductible	30% per prescription or refill. Deductible does not apply. The maximum copay per 1 month supply is $50.	40% per prescription or refill after deductible
Tier 2 Prescription Drugs Preferred brand*	40% per prescription or refill after deductible	30% per prescription or refill. Deductible does not apply. The maximum copay per 1 month supply is $125.	40% per prescription or refill after deductible
Tier 3 Prescription Drugs Non-preferred brand*	50% per prescription or refill after deductible	50% per prescription or refill. Deductible does not apply. The maximum copay per 1 month supply is $200.	50% per prescription or refill after deductible
Tier 4 Specialty Drugs*	50% per prescription or refill after deductible	50% per prescription or refill. Deductible does not apply. The maximum copay per 1 month supply is $400.	50% per prescription or refill after deductible

Benefit Summary

Benefits common to GeoBlue Options A and B:

(Subject to Medical Necessity and Maximums, Coinsurance, and Deductibles in Overview Matrix)

- Hospice Care Services
- Ambulatory Surgical Services
- Interruption of Pregnancy
- Obesity/Bariatric Surgery
- Organ Transplant Services
- Mental Health and Substance Use Disorder Treatment
- Gender Identity Disorder Treatment
- Nutritional Formulas
- TMJ Treatment
- Diabetic Equipment
- Durable Medical Equipment
- External Prosthetic Appliances
- Infusion Therapy
- Advanced Radiological Imaging
- Dental Services due to an Injury and Oral and Maxillofacial Treatment
- Inpatient Services at Other Heath Care Facilities – daily limitations apply
- Home Health Care Services - daily limitations apply
- Private Duty Nursing - daily limitations apply

Medical Assistance Services	
Emergency Medical Evacuation	Excluded
Repatriation of Mortal Remains	Excluded
Emergency Family Travel Arrangements	Not covered

DISCLAIMER: The entire plan, including benefits, exclusions, limitations and other important coverage provisions are shown in the Certificate of Coverage. The benefits or coverages shown in this summary may be changed to comply with state and federal requirements.