ExxonMobil International Health and Dental Plan

2025 Summary Plan Description

ExxonMobil

Table of Contents

Introduction

Overview

The information described in this document along with the Certificate and the Benefits at a Glance found on Cigna's ExxonMobil Educational Landing Page constitute the Summary Plan Description (SPD) for the ExxonMobil International Medical and Dental Plan (the Plan).

If there is a conflict or difference between this SPD and the ExxonMobil International Medical and Dental Plan document or the Certificate, the ExxonMobil International Medical and Dental Plan document or Certificate will govern, as applicable.

The ExxonMobil International Medical and Dental Plan is fully-funded. An insurance company collects premiums and underwrites coverage. Please contact Cigna for further details. ExxonMobil is responsible for determining the rules of eligibility for the Plan. Please contact ExxonMobil Benefits Service Center about the participation rules described in this SPD.

Plan Contact Information

When you need information, you may need to contact one or more of the following sources.

For copy of the Certificate:

To obtain a copy of the Certificate, log in into www.cignaenvoy.com. The Certificate can be found under the Announcements section on the Home page.

You can always request a copy of the Certificate by contacting Cigna Global Service Center at the numbers described below.

For claims administration:

Contact Cigna for pharmacy, medical/surgical, behavioral health and substance abuse claims forms, claims payment and other claims inquiries. Refer to the Certificate or Benefits at Glance documents for those services that may require prior authorization.

Phone numbers and website:

- Cigna Global Service Center Available 24 hours a day, 7 days a week You can search for network providers through www.cignaenvoy.com.

Benefits Administration

Customer Service Representatives can provide specialized assistance.

- Your Total Rewards portal (digital.alight.com/exxonmobil)
- Alight Mobile app (available through Apple App Store or Google Play)

References throughout this guide refer to the ExxonMobil Benefits Service Center

Phone numbers and Addresses:

ExxonMobil Benefits Service Center

Monday – Friday 8:00 a.m. to 4:00 p.m. (Central Time), except certain holidays

Toll-Free: 1-833-776-9966

ExxonMobil Benefits Service Center

DEPT 02694 - PO Box 64116

The Woodlands, TX, 77387-4116

ExxonMobil sponsored sites

EM Connect

Can be accessed at work by employees. ExxonMobil Family, the Human Resources Internet Site — Can be accessed by everyone at www.exxonmobilfamily.com. Your Total Rewards portal - can be accessed from home by everyone.

Administrative Information

Plan Name & Number	ExxonMobil International Medical and Dental Plan (636)
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, vision, and optional dental.
Administration & Funding	Fully insured.
Source of Contributions	Contributions will be paid out of the Corporation's general assets and through contributions paid by Eligible Employees and Retirees, in the amounts determined by the Corporation in its discretion.

Eligibility and Enrollment

Eligibility

All regular full-time or part-time expatriates whose home country is the U.S. ("expatriates"), all regular full-time or part-time expatriates whose host country is the U.S. ("impatriates"), and eligible dependent(s) of those individuals under the ExxonMobil expatriate guidelines are eligible to be enrolled in the International Medical and Dental plan.

You are not eligible if:

- You fail to make any required contribution toward the cost of the Plan.
- You fail to comply with general administrative requirements including but not limited to enrollment requirements.
- You lose eligibility as described under the Loss of eligibility section.
- Your coverage is prohibited under applicable law.

Eligible dependents

You may also elect coverage for your eligible dependent(s) including:

Married Spouses and Domestic Partners
Married spouses and domestic partners may be eligible to receive benefits under expatriate guidelines, if they meet the following criteria:

- Eligible for benefits under the employee's home country benefit plans (if any) at a level equal to that provided to a legally married spouse
- Able to reside permanently in the employee's home country
- Can secure a residency visa (not a tourist or visitor's visa) in the host country

In order to be eligible for coverage under the host or expatriate health care plan, married spouses/domestic partners must reside full-time (more than 50%) in the host country. If they continue to reside in your home country, they should continue to qualify for coverage under your home country health care plan.

Exceptions and special cases may arise for spouses and domestic partners:

- If a spouse or eligible dependents of an expatriate remain in the U.S., the spouse or eligible dependents will be eligible to be enrolled in this Plan while the expatriate is on assignment and will not be allowed to enroll in a different domestic ExxonMobil Medical Plan option.

- If an U.S. impatriate working temporarily in the U.S. is married to a regular U.S. employee, the regular U.S. employee may enroll the impatriate as a dependent under the domestic ExxonMobil medical plan option that they participate in.

Dependent Children
Eligible dependents may include your biological, adopted, and stepchildren who are under the age of 26.

Domestic partners' children may only be allowed to participate if such dependents are eligible for benefits under the employee's home country benefit plan and expatriate guidelines.

A totally and continuously disabled child(ren) age 26 or older who is incapable of self-sustaining employment by reason of mental or physical disability may be eligible to participate in this Plan as determined by the Administrator-Benefits.

Coverage Tiers

You can choose coverage as an:

- Participant only,
- Participant and spouse,
- Participant and child(ren), or
- Family

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

Double coverage

No one can be covered in more than one medical plan sponsored by Exxon Mobil Corporation or its affiliates. If your spouse or adult child works for the company, each of them can be covered:

- As an individual in the U.S. domestic plans,
- If you are on an expat assignment with a dual career or career accommodation, as an individual in the International Medical and Dental Plan.

If you become eligible for other ExxonMobil-sponsored health plans mid-month, coverage becomes effective when you are newly eligible for the new health plan or as otherwise determined by the Administrator-Benefits.

How to enroll

Regular full-time or part-time U.S. expatriates

You will have 30 days since the effective date of your assignment to confirm your medical and dental elections in the Your Total Rewards portal. Please note that the dental portion is optional.

If no action is taken:

- You will be automatically enrolled in the medical portion of this Plan as of the first day of the assignment.
- If you participated in ExxonMobil Dental plan, you will also be defaulted to this coverage.

Dependents of U.S. Expatriates (home country U.S.) will be automatically enrolled in the medical portion of this Plan if already enrolled in the employee's ExxonMobil Medical Plan and ExxonMobil Dental Plan (domestic plans), regardless of their status as an accompanying family member. If a U.S. expatriate (home country U.S.) had previously elected dental coverage in the U.S. but wishes to opt out of this Plan´s dental coverage, they must do so within 30 days by contacting the ExxonMobil Benefits Service Center.

U.S. impatriates

You will have 30 days since the effective date of your assignment to confirm your medical and dental elections in the Your Total Rewards portal. Please note that the dental portion is optional.

If no action is taken, you will be automatically enrolled in the medical portion of this Plan as of the first day of the assignment.

U.S. Impatriates (host country U.S.) are required to enroll any accompanying dependents into the ExxonMobil International Medical and Dental Plan by contacting the ExxonMobil Benefits Service Center by phone at 1-833-776-9966.

U.S. Impatriates can also to enroll in Dental coverage for themselves (if desired) by contacting the ExxonMobil Benefits Service Center within 30 days. If any enrollment occurs after the start of the assignment (i.e. a dependent joins the assignment as an accompanying dependent after assignment start date), coverage will not begin until the first of the month following when they join the U.S. impatriate on assignment.

If you fail to enroll your eligible dependent(s) in the medical or dental portions within 30 days, the next opportunity to enroll will be during annual enrollment with an effective date of the first day of the following year or upon a change in status event.

In the event of marriage, adoption or newborn child, please make sure you complete enrollment within 30 days of the event. In the case of marriage, coverage will be effective as of the first day of the month following enrollment. In the case of adoption or birth of a child, coverage will be retroactive to the date of the event and if this deadline is missed, the next opportunity to enroll is during annual enrollment, with coverage to be effective the first of the following year.

Note: You must enroll each new child for them to be covered, even if you already have family coverage.

You may be requested to provide documents at some future date to prove that the eligible dependent(s) 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 eligible dependent(s) will be cancelled the first of the following month and you may be subject to discipline up to and including termination of employment for falsifying company records. Please also refer to the Loss of eligibility section – Fraud against the Plan.

Annual Enrollment

Each year, ExxonMobil offers an annual enrollment period. During this time, you will only be able to:

- Add or delete eligible dependents. Changes elected during annual enrollment take effect the first of the following year.
- Opt in/out from the dental portion of this Plan.

NOTE: You should not wait until annual enrollment to remove a dependent who loses eligibility; they should be removed at the time eligibility is lost. For consequences of covering an ineligible eligible dependent, see Loss of Eligibility.

Changes in status

This section explains which events are considered changes in status and what changes you may make as a result. If you have a change in status, you must complete your change within 30 days for most changes in status (and 60 days in the case of divorce or if you, your spouse or your covered dependent gains or loses eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage). If you do not complete your change within this time period, changes to your coverage may be limited.

For U.S. expatriates, if you fail to remove an ineligible dependent(s) within 30 or 60 days of the event that causes the person to no longer be eligible as described above, (e.g., divorce) you must continue to pay the same pre-tax contribution for coverage even though you have removed that ineligible person. Your pre-tax contribution for coverage will remain the same until you have another change in status or the first of the plan year following the next Annual Enrollment period. The only exception is death of an eligible dependent.

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

If this event occurs...	You may...
Marriage	Enroll your spouse and any new eligible dependent(s).
Divorce – Employee and spouse enrolled in ExxonMobil International Medical and Dental Plan	Change your level of coverage. **You must remove coverage for your former spouse and stepchild(ren).**
Gain an eligible dependent through birth, adoption or placement for adoption, sole court appointed legal guardian or sole managing conservator	Enroll any eligible dependent(s) and change your level of coverage, if needed.
Death of a spouse or other eligible dependent	Change your level of coverage. You may not cancel coverage for yourself or other covered eligible dependents.
An eligible dependent loses eligibility under another employer's plan or other employer contributions cease which creates a "HIPAA special enrollment" right	Enroll your eligible dependents who might have lost eligibility under another employer's plan. Change your level of coverage, if needed.
Other loss of eligible dependent's eligibility (e.g., sole managing conservatorship of grandchild ends)	Change your level of coverage. You may not cancel coverage for yourself or other eligible dependents.

Your former spouse is ordered to provide coverage to your children through a QMCSO	End the eligible dependent's coverage, change level of coverage and terminate their participation in the ExxonMobil International Medical and Dental Plan.
Commencement of Employment by spouse or other eligible dependent or other change in their employment status (e.g., change from part-time to full-time) triggering eligibility under a different employer sponsored plan.	End spouse or eligible dependent's coverage and terminate their participation in the ExxonMobil International Medical and Dental Plan.
Your spouse, or eligible dependent becomes entitled to Medicare or Medicaid.	You may choose to change level of coverage related to the eligible dependent as long as they are eligible to enroll in Medicare/Medicaid.
Judgment, decree or other court order requiring you to cover an eligible dependent. (e.g., begin a QMCSO)	Change level of coverage.
You begin or return from a leave of absence	You may be able to make changes to some health plan benefits. Contact ExxonMobil Benefits Service Center at 833-776-9966 with any questions.
Your expatriate assignment outside of the U.S. ends.	You will have 30 days from the repatriation date to confirm your elections in Your Total Rewards portal. If no action is taken, you will be defaulted to the ExxonMobil Medical Plan – POS A option and the ExxonMobil Dental Plan (only if you were enrolled in the dental portion of this plan at the end of your assignment). Please note that Vision enrollment will not be automatic; you will need to proactively enroll upon your return.

Marriage

If you are enrolled in the ExxonMobil International Medical and Dental Plan, you can enroll your new spouse and stepchildren for coverage, if they are considered eligible dependents. You must make these changes within 30 days following the date of your marriage or wait until Annual Enrollment or another change in status.

Note: You are not allowed to opt-out of the ExxonMobil International Medical and Dental plan if you gain coverage under your spouse's health plan.

Divorce

In the case of divorce, your former spouse and any stepchildren are eligible for coverage only through the end of the month in which the divorce is final. You must notify and provide any documents if requested to the ExxonMobil Benefits Service Center as soon as your divorce is final. If you fail to notify or provide the requested documentation to the ExxonMobil Benefits Service Center within 60 days, the former spouse and eligible dependent will not be entitled to elect COBRA. Please see the Continuation coverage section of this SPD. There may also be consequences for falsifying company records. You may not make a change to your coverage if you and your spouse become legally separated because there is no impact on eligibility.

If you do not complete your change within 60 days, any contributions you make for ineligible dependents will not be refunded. For US expatriates, pre-tax contributions will not be reduced until the beginning of the next calendar year. Any claims paid after the loss of eligibility must be repaid by you.

Birth, adoption or placement for adoption

If you gain an eligible dependent through birth, adoption, or placement for adoption you may add the new **eligible dependent** to your current coverage. Coverage is effective on the date of birth, adoption or placement for adoption if you enroll your eligible dependent within the first 30 days. If you miss to enroll your eligible dependents within 60 days, the next opportunity to enroll will be during annual enrollment and the effective date of coverage shall be the first day of the following year.

You must add the new eligible dependent within 30 days even if you already have family coverage.

Death of a spouse

If you and your eligible dependents are enrolled in the ExxonMobil International Medical and Dental Plan, any stepchildren will cease to be eligible upon your spouse's death unless you are their court appointed guardian or sole managing conservator.

Sole legal guardianship or sole managing conservatorship

If you (or your spouse, separately or together) become the sole court appointed legal guardian or sole managing conservator of a child and the child meets all other requirements of the definition of an eligible child, you have 30 days from the date the judgment is signed to enroll the child for coverage. You must provide a copy of the court document signed by a judge appointing you (or your spouse separately or together) guardian or sole managing conservator.

When a child is no longer eligible

If an enrolled eligible dependent no longer meets the eligibility criteria, coverage continues through the end of the month in which they cease to be eligible. In some cases, continuation coverage under COBRA may be available. (See Continuation coverage for more details about COBRA.) You must notify and provide the appropriate forms to the ExxonMobil Benefits Service Center as soon as an eligible dependent is no longer eligible. If you fail to notify and provide the appropriate forms to the ExxonMobil Benefits Service Center within 60 days, the eligible dependent will not be entitled to elect COBRA. While we have an administrative process to remove dependent children reaching the maximum eligibility age, you remain responsible for ensuring that the dependent child is removed from coverage. If you fail to remove the ineligible dependent in a timely manner, there may be consequences for falsifying company records.

Leave of absence

If you are on an approved unpaid leave of absence, you may continue coverage by making required contributions directly to this Plan by check. If you choose not to continue your coverage while on leave, your coverage ends on the last day of the month in which the cancelation form is received by the ExxonMobil Benefits Service Center, and you will be required to pay for the entire month's contributions. If you fail to make required contributions while on leave, coverage will end.

If the company should make any payment on your behalf to continue your coverage while you are on leave and you decide not to return to work, you will be required to reimburse the company for required contributions.

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

For more information, contact the ExxonMobil Benefits Service Center.

Other situations that may affect your coverage

If you retire

If you are a U.S. expatriate and you decide to retire, you may be eligible for the ExxonMobil Retiree Medical Plan (EMRMP) or you may elect COBRA to stay in this Plan for the duration of COBRA coverage. If you retire as a regular employee and you are Medicare-eligible, you may be eligible to enroll in the Medicare Primary Option (MPO) option of the EMRMP. Please refer to the EMRMP Summary Plan Description for eligibility and enrollment requirements.

If a U.S. expatriate continues to work beyond the date of eligibility for Medicare

If you are eligible for Medicare while you are still on an active expatriate assignment, this Plan will be primary to your Medicare benefits, if any. Refer to **www.medicare.gov** to learn more about Medicare while you are still employed.

If your covered eligible dependents become Medicare eligible for any reason

Eligible dependents of a U.S. expatriate who become Medicare eligible, either due to age or Social Security disability status, are eligible to continue to participate in this Plan as their primary plan option as long as the U.S. expatriate remains on assignment.

If the U.S. expatriate retires or dies, and coverage is available under the EMRMP:

- Medicare eligible covered spouses must enroll in Medicare Primary Option, including enrolling in Medicare Parts A and B.
- All eligible dependent children under the age of 26 (including those that are Medicare eligible) and those over the age of 26 who are totally and continuously disabled and not Medicare eligible, may enroll in the Retiree Medical Plan options of the EMRMP.
- Medicare eligible dependent children over the age of 26 are not eligible for coverage under any ExxonMobil medical plan available to retirees. You may be eligible to elect continuation coverage for your Medicare eligible dependent child under COBRA provisions. See **Continuation coverage** for details.

If you die

If you are a U.S. expatriate and die while enrolled, your covered surviving spouse may be eligible to continue coverage under the ExxonMobil Retiree Medical Plan. Their eligibility continues with the EMRMP for a specified amount of time:

- If you have 15 or more years of benefit service at the time of your death, eligibility continues until your spouse remarries, becomes eligible for Medicare or dies. Upon eligibility for Medicare, your spouse can continue coverage through the Medicare Primary Option.
- If you have less than 15 years of benefit service, eligibility continues for twice your length of benefit service or until your spouse remarries, becomes eligible for Medicare, or dies, whichever occurs first. Upon eligibility for Medicare, the surviving spouse may continue coverage through the Medicare Primary Option only until the end of the applicable period.

Children of deceased U.S. expatriates may continue participation as long as they are eligible dependents. The length of their coverage will depend on the years of service of the U.S. expatriate as described above. Stepchildren will lose eligibility if the U.S. expatriate surviving spouse remarries.

If you are a U.S. impatriate, COBRA continuation coverage may be available for your dependents up to 36 months from the date of the event

How the ExxonMobil International Medical and Dental Plan works

Open Access Plus Medical Benefits provide coverage for care inside the United States (in-network and out-of-network) and internationally (outside the United States). To receive Open Access Plus Medical Benefits, you and your eligible dependents may be required to pay a portion of the covered expenses for services and supplies such as a copayment, deductible or coinsurance, if any. Please refer to the in-network benefits schedule found on **www.cignaenvoy.com** for details.

If you are unable to locate an in-network provider in your area who can provide you with a service or supply that is covered under this Plan, you must call the number on the back of your ID card to obtain authorization for out-of-network provider coverage. If you obtain authorization for services provided by an out-of-network provider, benefits for those services will be covered at the in-network benefit level.

For full information about covered and non-covered expenses and plan limitations for your medical, dental, vision and prescription plan benefits, refer to the Certificate on the Cigna website at **www.cignaenvoy.com**.

When your coverage ends.

Coverage for you and/or your eligible dependents ends on the earliest of the following dates:

- The last day of the month in which your expatriate assignment ends
- your eligible dependents are no longer eligible; or

1. this Plan is terminated; or
2. a covered person fails to make any required contribution; or
3. a qualified medical child support order is no longer in effect for an eligible dependent; or
4. as of the date the expatriate employee dies or the date the survivor is moved to the home country medical plan, if applicable.

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

Loss of eligibility

Fraud against the plan

Everyone in your family may lose eligibility under this Plan, and 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 that you recover from a third party. Additionally, coverage may be terminated if you fail to reimburse the Plan for any amount owed to the Plan, or if you receive and fail to report to the Claims Processor any discounts, write-offs, or other arrangements with providers that result in misrepresentation of your out-of-pocket costs. Your participation may be terminated if you fail to comply with the terms of the Plan and its administrative requirements. You may also lose eligibility if you enroll persons who are not eligible, for instance, by covering eligible dependents who do meet the eligibility requirements. This includes failing to provide timely notification of when a covered eligible dependent loses eligibility, e.g., spouse loses eligibility due to divorce.

Continuation benefits for U.S. expatriates terminated due to disability.

U.S. expatriates with less than 15 years of service who are terminated in connection with a long-term disability may be provided with COBRA coverage at no cost for the first 12 months. To be entitled to this benefit, you must elect COBRA upon termination of employment and receive long term disability benefits under the ExxonMobil Disability Plan.

The 12-month period runs concurrently with your COBRA continuation period, and you will be responsible for paying the full cost after for the remainder of your COBRA continuation period.

Continuation coverage for eligible dependents may be available through COBRA, but this coverage will not be covered by the Company.

Continuation coverage

Introduction

You are required to be given the information in this section because you are covered under a group health plan (the ExxonMobil International Medical and Dental Plan). This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan under certain circumstances when coverage would otherwise end. This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to your spouse and children, if they are covered under the Plan when they would otherwise lose their group health coverage or other rights under the Plan. This section does not fully describe COBRA coverage or other rights under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should review this SPD or contact the COBRA Administrator (Alight) at 855-250-4170.

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

Determination of Benefits Administration Entity to Contact: current ExxonMobil and XTO employees, their covered family members and former ExxonMobil Employees and their covered family members, who have elected and are participating through COBRA should all contact ExxonMobil Benefits Service Center at 1-833-776-9966 (Monday – Friday 8:00 a.m. to 4:00 p.m. CST) or access Your Rewards portal.

The contact information for each of these entities is as shown in the Contacts for COBRA Rights Under the ExxonMobil Medical Plan section.

What is COBRA coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a qualifying event. Specific qualifying events are listed later in this section. If a specific qualifying event occurs and any required notice of that event is properly provided to the ExxonMobil Benefits Service Center, COBRA coverage must be offered to each person losing coverage who is a qualified beneficiary. You, your spouse, and your children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below. Under the Plan, qualified beneficiaries who elect COBRA coverage must pay the entire cost of COBRA coverage (employee plus employer portions) plus a 2% administrative fee.

Who is entitled to elect COBRA?

If you are an employee, you will be entitled to elect COBRA, if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will be entitled to elect COBRA if you lose coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies,
- Your spouse's hours of employment are reduced,
- Your spouse's employment ends for any reason other than his or her gross misconduct,
- You become divorced from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce, and a divorce later occurs, then the divorce may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce.

A person enrolled as the employee's child will be entitled to elect COBRA if he or she loses coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies,
- The parent-employee's hours of employment are reduced,
- The parent-employee's employment ends for any reason other than his or her gross misconduct, or

The child stops being eligible for coverage under the Plan as a child.

When is COBRA coverage available?

When the qualifying event is the end of employment or reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need to notify the ExxonMobil Benefits Service Center of any other qualifying events.

For the other qualifying events, a COBRA election will be available to you only if you notify the ExxonMobil Benefits Service Center. You must notify the Benefits Service Center of the loss of your eligibility or your ineligible family members within 30 days from the date of the event except for the events of divorce or loss of Medicaid or Children's Health Insurance Program (CHIP) coverage of you, your spouse or dependent for which you have up to 60 days to report. You may enroll in COBRA continuation coverage within 60 days from the later of the date coverage is lost or the date on the COBRA Election Notice statement. Current employees may give notice of qualifying events by logging onto Your Total Rewards portal.

Please note: Notice is not effective until either a change is made on Your Total Rewards Portal or the proper information is received by the ExxonMobil Benefits Service Center. If notice is not submitted during the 30 or 60-day notice period depending on the change in status, then all qualified beneficiaries will lose their right to elect COBRA.

Election of COBRA

Each qualified beneficiary will have an independent right to elect COBRA. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all qualified beneficiaries, and parents may elect

COBRA on behalf of their children. **Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA.**

How long does COBRA coverage last?

COBRA coverage is a temporary continuation of Plan coverage that lasts between 18-36 months depending on the qualifying event.

You, your spouse and covered dependents may qualify for up to 18 months of continuation coverage, if you qualify due to one of the following qualifying events:

- Your employment ends for any reason other than termination for gross misconduct;
- Your work hours are reduced, and you are no longer eligible to participate in the Plan; or
- Unpaid Leave of Absence

Your covered spouse and covered dependent may qualify for up to 36 months of continuation coverage, if they qualify due to one of the following qualifying events:

- You die;
- You and your spouse get a divorce; or

An enrolled child no longer meets the definition of "child" under the terms of the Plan

Second qualifying event extension COBRA coverage

If your family experiences another qualifying event while receiving COBRA coverage as a result of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension as described above), the covered spouse and children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given the COBRA Administrator. This extension may be available to the spouse and any children receiving COBRA coverage if the employee or former employee dies, gets divorced, or if the covered child stops being eligible under the Plan as a child. This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her **termination of employment or reduction of hours. This extension due to a second qualifying event is available only if you notify the correct benefits administration entity** within 60 days of the date of the second qualifying event.

Disability extension of 18-month COBRA continuation coverage

The 18-month continuation period may be extended for you and your covered family members if the Social Security Administration determines that you or another family members, who is a qualified beneficiary, is disabled at any time during the first 60 days of continuation coverage. If all of the following requirements are met, coverage for all family members who are qualified beneficiaries as a result of the same qualifying event can be extended for up to an additional 11 months (for a total of 29 months):

- This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours.
- The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

- A copy of the Notice of Award from the Social Security Administration is provided to the COBRA Administrator [ExxonMobil Benefits Service Center] within 60 days of receipt of the notice and before the end of the initial 18 months of continuation coverage.
- If the disabled qualified beneficiary elects continuation coverage, you must pay an increased premium of 150 percent of the monthly cost of Plan coverage that's continued, beginning with the 19th month of continuation coverage.

Extension Due to Medicare Eligibility

Coverage may also last up to 36 months for a covered spouse or covered dependent when loss of coverage is the result of a qualifying event that is the end of the employee's employment or the reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event. In this case, COBRA coverage under the Plan for qualified beneficiaries (other than the employee) may last until up to 36 months after the date of the employee's Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before termination or reduction of hours.

When COBRA Coverage Ends

COBRA coverage may be terminated before the maximum period if one of the following occurs:

- The premium for your continuation coverage is not paid on time.
- If after electing continuation coverage, you become covered by another group health plan, unless the plan contains any exclusions or limitations with respect to any pre-existing condition you or your coverage dependents may have.
- If after electing continuation coverage, you first become eligible for and enroll in Medicare Part A, Part B or both.
- You extend coverage for up to 29 months due to a qualified beneficiary's disability and there has been a final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. In this case, continuation coverage will end on the first of the month that begins more than 30 days after the final determination o by the Social Security Administration that the qualified beneficiary is no longer disabled. This will be the case only if the qualified beneficiary has been covered by continuation coverage for at least 18 months.

Exxon Mobil Corporation no longer provides group health coverage to any of its eligible employees or eligible retirees.

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a special enrollment period. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

More information about individuals who may be qualified beneficiaries during COBRA

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself.

The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise-applicable Plan eligibility requirements (for example, regarding age).

Alternate recipients under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by ExxonMobil during the covered employee's period of employment with ExxonMobil is entitled to the same rights to elect COBRA as an eligible child of the covered employee.

Cost of COBRA coverage

A person who elects continuation coverage may be required to pay 102% of the cost to the Plan to maintain the coverage, unless the person is entitled to extended coverage due to disability. If the person becomes entitled to such extended coverage due to disability, the person may be required to contribute up to 150% of contributions after the initial 18-month's coverage until coverage ends. A person who elects continuation coverage must pay the required contributions within 45 days from the date coverage is elected retroactively to the date benefits terminated under the Plan.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep your plan informed of address changes

In order to protect your family's rights, you should keep 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.

Contacts for COBRA rights under the ExxonMobil Medical Plan

For employees and former employees currently participating in the EMMP through COBRA:

ExxonMobil Benefits Service Center
Phone: 833-776-9966
Hours: 8am – 4pm CST, Monday through Friday, except certain holidays
Your Total Rewards portal: digital.alight.com/exxonmobil

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

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

FAILURE TO NOTIFY THE CORRECT ENTITY COULD RESULT IN YOUR LOSS OF COBRA RIGHTS.

Filing Claims and Appeals

In general, health services and benefits must be medically necessary to be covered under the Plan. The procedures for determining medical necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical necessity determinations are made on either a pre-service, concurrent, or post-service basis as described in the Certificate under section Claim Determination Procedures under ERISA, in page 77.

Notice of adverse determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; (6) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

Please refer to page 77 of the Cigna Plan certificate for further information.

When you have a complaint or an appeal

The Plan makes available both an internal and external appeal procedure for medical necessity or clinical appropriateness determinations. The internal appeals has two-steps referred to as the level one appeal and level two appeal. To initiate an internal appeal for most claims, you must submit a request to Cigna within 365 days of receipt of a denial notice. For more information about the internal appeal process, please refer to section When you have a complaint or an appeal of the Cigna Plan Certificate on page 83.

Appeals may be submitted to the following address:

Cigna

ATTN: Appeals Department

P.O. Box 15800

Wilmington, DE 19850

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call Cigna at the toll-free number on your ID card, explanation of benefits or claim form.

Independent Review of Appeals

If you are not fully satisfied with the decision of Cigna's internal level two appeal review, you may request that your medical appeal relating to a medical necessity or appropriateness denial be referred to an Independent Health Care Appeals Program (IHCAP) and conducted by an Independent Utilization Review Organization (IURO) assigned by the State of Delaware. For medical and dental appeals denials based on grounds other than medical necessity or appropriateness you may request that your appeal be referred to arbitration by submitting a petition to the Delaware Insurance Department. Please refer to the section When you have a complaint or an appeal of the Cigna Plan Certificate on page 83.

Notice of benefit determination on appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific plan provisions on which the determination is based; (4) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (5) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (6) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and (7) information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office or the Plan Administrator.

Please refer to pages 83-87 of the Certificate for more details.

Relevant information

Relevant Information is any document, record or other information which: was relied upon in making the benefit determination; was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Administrative and ERISA Information

Applicable Law

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

Forum and Venue

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

Plan Amendment & Termination

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

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

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

Merger or Consolidation

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

Nonalienation of Benefits

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

Missing Persons

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

Uncashed Checks

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

Plan's Right to Recover Overpayments

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

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

Delegation of Duties

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

Collective bargaining agreements

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

No implied promises

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

Legal Notices

ERISA Rights Statement

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

Receive Information About Your Plan and Benefits

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

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

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

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

Continue Group Health Plan Coverage

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

Prudent Action by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest Annual Report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Administrator-Benefits to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator-Benefits. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

Assistance With Your Questions

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

HIPAA Privacy Notice

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

Uses & Disclosures of Your Information

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

Genetic Information Nondiscrimination Act ("GINA")

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

Plan Sponsor

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

Exceptions

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

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

Authorization

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

Marketing/Sale of PHI and/or Psychotherapy Notes

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

Revoke

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

Stricter State Privacy Laws

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

Your Rights With Respect To Your Health Information

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

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

Our Duties With Respect To Your Individually Identifiable Health Information

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

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

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

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

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

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

Medicare Prescription Drug Plan Information

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

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

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

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

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

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

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

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

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

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

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

Visiting www.medicare.gov

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

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

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

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

2025

ExxonMobil International Medical and Dental Plan

ExxonMobil Benefits Service Center

Dept 02694, PO Box 64116

The Woodlands, TX, 77387-4116

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Women's Health & Cancer Rights Act

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

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

Newborns' Mothers' Health Protection Act

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

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

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

Other Legal Notices

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