Insured and/or administered by:

Cigna Health and Life Insurance Company

Exxon Mobil Corporation

Benefits at a Glance
Global Plan for
Third Country Nationals
Policy # 00863B
Plan Start Date January 1, 2022

This plan provides minimum essential coverage.

Please Note: This is a high level summary of your benefits. Please see your certificate booklet for detailed benefits and exclusions.

Cigna Global Customer Service		
Toll Free Telephone Number:	1.800.441.2668	
Direct Telephone:	**1.302.797.3100 (collect calls accepted)**	
Toll Free Fax Number:	**1.800.243.6998**	
Direct Fax Number:	**001.302.797.3150**	
Secure Website:	www.CignaEnvoy.com. Registration is required (See member kit for registration information.) Secure email available at this site.	
Mail Delivery:	Cigna Global Health Benefits P.O. Box 15050 Wilmington DE 19850-5050 U.S.A.	Cigna Global Health Benefits 300 Bellevue Parkway Wilmington DE 19809 U.S.A.

General Plan Provisions - All Amounts in U.S. Dollars

Global Medical Plan	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Area of Cover	Worldwide		
U.S. Medical Network	Open Access Plus (OAP)		
Lifetime Maximum	Unlimited		
Calendar Year Deductible · Per Individual · Per Family	 $300 $600	 $300 $600	 $400 $800
Coinsurance (The percentage of covered expenses the plan pays)	80%	80%	60%
Out-of-Pocket Maximum (Includes Deductible) · Per Individual · Per Family	 $1,500 $3,000	 $3,000 $6,000	 $15,000 $30,000
Deductible Calculation	Claims for a family member are covered at plan coinsurance: • When that family member satisfies the Individual Deductible -OR- • When the Family Deductible is satisfied regardless of whether or not the Individual Deductible is satisfied.		

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Global Medical Plan

Out-of-Pocket Calculation	Claims for a family member are covered at 100% coinsurance: • When that family member satisfies the Individual Out-of-Pocket Maximum -OR- • When the Family Out-of-Pocket Maximum is satisfied regardless of whether or not the Individual Out-of-Pocket Maximum is satisfied. Out-of-Pocket will: Include deductible payments; Include copay payments; Include pharmacy copays; Include pharmacy coinsurance payments; Exclude Pre-Admission Certification/Continued Stay Review penalties.
Network Accumulation	Plan Deductible, Out-of-Pocket, maximums and service specific maximums (dollar and occurrence) will cross-accumulate across international and domestic networks.

Certification Requirements - For services rendered inside the United States

Precertification for inpatient and outpatient services received in the U.S. may be required.

- Providers must call our toll-free number, 1.800.441.2668 to pre-certify services.
- You or your dependents are responsible for ensuring that Out-of-Network providers pre-certify services.
- Failure to obtain precertification may affect Out-of-Pocket costs.
- This is a summary only and further details can be found in the certificate booklet.

	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Physician's Services · Physician's Office Visit – Primary*	80% after deductible	$25 copay not subject to deductible	60% after deductible
· Physician's Office Visit - Specialist* * Includes surgery performed In the Physician's Office	80% after deductible	$40 copay not subject to deductible	60% after deductible
Telehealth Physician Consultation (see Global Wellness and Telehealth below)	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Preventive Care · Routine Preventive Care - all ages · Immunizations - all ages	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Travel Immunizations (Immunizations as required for travel)	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Inpatient Hospital Facility Services	80% after deductible	80% after deductible	60% after deductible
Inpatient Hospital Physician Visits/Consultations	80% after deductible	80% after deductible	60% after deductible
Outpatient Facility Services	80% after deductible	80% after deductible	60% after deductible
Emergency Room	80% not subject to deductible	$100 copay not subject to deductible	$100 copay not subject to deductible
Urgent Care Facility	80% after deductible	$40 copay not subject to deductible	60% after deductible
Ambulance	100% after deductible	100% after deductible	100% after deductible

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Global Medical Plan			
	International (Outside of the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Laboratory and Radiology Services (including pre-admission testing)	80% after deductible	80% after deductible	60% after deductible
Advanced Radiology (i.e., MRIs, MRAs, CAT Scans, PET Scans)	80% after deductible	80% after deductible	60% after deductible
Short-Term Rehabilitation Calendar Year Maximum: 60 Days for all Therapies Combined *Includes:* Cardiac and Pulmonary Rehab, Speech, Occupational and Cognitive Therapy **Note:** The Short-Term Rehabilitation Therapy maximum does not apply to the treatment of Autism and/or Mental Health conditions	80% after deductible	$40 copay not subject to deductible	60% after deductible
Short-Term Rehabilitation Physical Therapy / Physiotherapy Calendar Year Maximum: Unlimited	80% after deductible	80% after deductible	60% after deductible
Chiropractic Care Calendar Year Maximum: Unlimited	80% after deductible	80% after deductible	60% after deductible
Maternity Care Services			
· Initial Visit to Confirm Pregnancy	80% after deductible	$25 copay not subject to deductible	60% after deductible
· All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	80% after deductible	80% after deductible	60% after deductible
· Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	80% after deductible	$25 copay not subject to deductible	60% after deductible
· Delivery – Facility (Inpatient Hospital, Birthing Center)	80% after deductible	80% after deductible	60% after deductible
Infertility Treatments	Diagnosis of Infertility is covered under general Physician Office Visits.		
· Gift, Zift	80% after deductible	100% not subject to deductible	60% after deductible
· Invitro	80% after deductible	100% not subject to deductible	60% after deductible
· Artificial Insemination	80% after deductible	100% not subject to deductible	60% after deductible

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Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Hearing Benefit · 1 Exam Every 24 Months	80% after deductible	80% after deductible	60% after deductible
Hearing Device / Aids **Adults** · 1 Per Ear max of $2,500 every 5 years	80% after deductible	80% after deductible	60% after deductible
Hearing Device / Adults **Dependents Up to Age 24** . 1 Per Ear max of $2,500 every 3 years	80% after deductible	80% after deductible	60% after deductible
Mental Health and Substance Use Disorder · Inpatient Facility	80% after deductible	80% after deductible	60% after deductible
· Outpatient Office Visit	80% after deductible	$25 copay not subject to deductible	60% after deductible

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Prescription Drug Benefits		
International (Outside of the U.S.)		
Purchased outside the United States	Member pays 20% after plan deductible	
Certain preventive care medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no copayment or deductible, when purchased from a Network Pharmacy. A written prescription is required.		
Purchased Inside the United States Only		
Benefit Highlights	**Network Pharmacy (U.S. In-Network)**	**Non-Network Pharmacy (U.S. Out-of-Network)**
Prescription Drug Products at Retail Pharmacies	**The amount you pay for up to a consecutive 30-day supply**	
Generic	Member pays 20% not subject to plan deductible $50 maximum	Member pays 40% after plan deductible
Preferred Brand Name	Member pays 20% not subject to plan deductible $125 maximum	Member pays 40% after plan deductible
Non-Preferred Brand Name	Member pays 20% not subject to plan deductible $200 maximum	Member pays 40% after plan deductible
Prescription Drug Products at Home Delivery Pharmacies	**The amount you pay for up to a consecutive 90-day supply**	
Generic	Member pays 20% not subject to plan deductible $150 maximum	In-Network coverage only
Preferred Brand Name	Member pays 20% not subject to plan deductible $375 maximum	In-Network coverage only
Non-Preferred Brand Name	Member pays 20% not subject to plan deductible $600 maximum	In-Network coverage only
Pharmacy Plan Features for Prescriptions Drugs Purchased Inside the United States Only		
Dispense As Written	If you request to fill a brand name drug that has a generic equivalent available, you will be financially responsible for the difference in cost between the brand name and the generic drug, plus any required brand name drug copayment and/or coinsurance, if applicable. However, if your doctor has determined a generic drug is not an acceptable alternative for you, you will only be responsible for payment of the appropriate brand name drug copayment and/or coinsurance, if applicable	
Prescription Drug List	Performance 3-Tier	
Step Therapy	Certain drugs are subject to step therapy requirements. To identify whether a particular drug is subject to step therapy, please refer to your prescription drug list.	
Prior Authorization	Coverage for certain drugs require your Physician to obtain prior authorization from Cigna. To identify whether a particular drug requires prior authorization, please refer to your prescription drug list.	
To see if your medication is covered, you can view Cigna's Prescription Drug List by going to www.Cigna.com/druglist and select "Performance 3-Tier"		

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Global Wellness and Telehealth	
Global Wellness Benefit	Included
Telehealth (accessible using the Cigna Wellbeing App™)	- 24/7/365 access to a doctor within 24-72 hours available globally in multiple languages - Access to 110+ board certified doctors – internal medicine, gastroenterology, orthopedics, mental health specialists and pediatricians - Affordable and convenient alternative to doctor or clinic visits – with no deductibles or coinsurance, and no need to leave the house - Mobile app access to real-time scheduling - No cost for the appointment - For more info: GLOBAL WELLBEING APP AND FAQS

Global Vision Plan			
	International (Outside of the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Examinations One every 12 consecutive months	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Lenses and Frames or Contacts (Hardware) One every 12 consecutive months	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Exam Maximum Benefit	Unlimited		
Hardware Maximum Benefit	$250		

Global Dental Plan		
Calendar Year Maximum Combined for: Class I Class II Class III		$1,000
Lifetime Class IV Maximum		$1,000
Calendar Year Deductible Combined for: Class II Class III		$50 Individual / $150 Family
Class I	**Preventive Care** For diagnostic and preventative services including: • Oral Exam -2 Per Person Per Year • Cleanings -2 Per Person Per Year • Bitewing X-rays -2 Per Person Per Year • Fluoride Applications -1 Per Person Per Year (Up to age 19) • Sealants -1 Per Person Per 3 Years • Diagnostic X-rays –Unlimited • Full Mouth / Panoramic X-rays -1 Per Person Per 3 Years	100% not subject to deductible
Class II	**Basic Restorative** For Basic Restorations: • Endodontics • Periodontics • Prosthodontics Maintenance • Oral Surgery • Fillings • Root Canal • Periodontal Scaling and Root Planing • Repair to Bridgework and Dentures	80% after deductible
Class III	**Major Restorative** For Major Restorations: • Dentures • Bridgework • Crowns	50% after deductible
Class IV	**Orthodontia** Children up to Age 19	50% not subject to deductible
Class V	**Implants**	Not Covered