The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-622-5501, or go to hr.conocophillips.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary.

Important Questions	Answers		Why This Matters:
What is the overall deductible?	**In-Network:** $**3,000** Individual $**6,000** Family	**Non-Network:** **$6,000** Individual **$12,000** Family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
	Includes medical and prescription drug costs. Does not apply to preventive care in-network.		
Are there services covered before you meet your deductible?	Yes, preventive care- routine physical exams		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits .
Are there other deductibles for specific services?	No		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Yes. In-Network:** **$6,000** Individual **$12,000** Family	**Yes. Non-Network:** **$12,000** Individual **$24,000** Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
	Includes medical and prescription drug costs.		
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for services, health care this plan doesn't cover, and charges in excess of reasonable and customary amounts as defined in the plan document.		Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a	Yes. For a list of in-network providers, see		This plan uses a provider network. You will pay less if you use a provider in

network provider?	**www.bcbstx.com** or call **1-800-343-4709.**	the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a referral.

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance, subject to allowed amount	None
	Specialist visit	20% coinsurance	40% coinsurance, subject to allowed amount	None
	Preventive care/screening/ immunization	No Charge	No charge up to $1,500, then 40% coinsurance, subject to allowed amount, deductible waived	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance, subject to allowed amount	Some services require pre-authorization. See Preventive Care for services billed as preventive.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance, subject to allowed amount	Some services require pre-authorization

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or by calling 1-855-293-4118.	Generic drugs	You pay 100% until deductible is met, then 20% coinsurance.	You pay 100% until the deductible is met, then 40% coinsurance plus amounts above the subject to allowed amount	Retail covers up to a 30-day supply. Mail order/Maintenance Choice covers up to a 90-day supply.
	Preferred brand drugs	You pay 100% until deductible is met, then 20% coinsurance.	You pay 100% until the deductible is met, then 40% coinsurance plus amounts above the subject to allowed amount	You pay 100% of the difference in cost if you obtain a brand name drug when a generic brand is available.
	Non-preferred brand drugs	You pay 100% until deductible is met, then 20% coinsurance.	You pay 100% until the deductible is met, then 40% coinsurance subject to allowed amount	You pay 100% of the cost for maintenance medications if not obtained via mail order / Maintenance Choice after the second refill.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	You pay 100% until deductible is met, then 20% coinsurance.	You pay 100% until the deductible is met, then 40% coinsurance plus amounts above the negotiated/ discounted rate. You pay 100% of the cost of injectable medications obtained out-of-network.	You pay the full price and then file a claim if using a non-network provider. Certain drugs may require pre-authorization or are subject to utilization rules. Prescriptions for certain self-injectable and oral medications must be submitted to prescription drug claims administrator.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance, subject to allowed amount	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance, subject to allowed amount	None
If you need immediate care	Emergency room care	20% coinsurance for emergency 50% coinsurance for non-emergency	20% coinsurance for emergency 50% coinsurance for non-emergency, subject to allowed amount	None
	Emergency medical transportation	20% coinsurance for emergency, no coverage for non-emergency	20% coinsurance for emergency, no coverage for non-emergency	None
	Urgent care	20% coinsurance	40% coinsurance, subject to allowed amount	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance, subject to allowed amount	Pre-authorization may be required. Benefits will be reduced by $200 if non-network hospital pre-authorization is not obtained.
	Physician/surgeon fees	20% coinsurance	40% coinsurance, subject to allowed amount	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance, subject to allowed amount	Managed by Beacon Health Options.
	Inpatient services	20% coinsurance	40% coinsurance, subject to allowed amount	Pre-authorization may be required for non-emergency situations. Managed by Beacon Health Options.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance, subject to allowed amount	None
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance, subject to allowed amount	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance, subject to allowed amount	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance, subject to allowed amount	Coverage is limited to 120 visits per calendar year. Pre-authorization required for non-network care. Benefits will be reduced by $200 if pre-authorization is not obtained.
	Rehabilitation services	20% coinsurance	40% coinsurance, subject to allowed amount	Combined maximum of 60 visits per calendar year
	Habilitation services	20% coinsurance	40% coinsurance	Combined maximum of 60 visits per calendar year
	Skilled nursing care	20% coinsurance	40% coinsurance, subject to allowed amount	Coverage is limited to 60 days per calendar year. Pre-authorization required for non-network care. Benefits will be

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				reduced by $200 if pre-authorization is not obtained.
	Durable medical equipment	20% coinsurance	40% coinsurance, subject to allowed amount	None
	Hospice services	20% coinsurance	40% coinsurance, subject to allowed amount	Pre-authorization required for non-network care. Benefits will be reduced by $200 if pre-authorization is not obtained
If your child needs dental or eye care	Children's eye exam	No charge if performed as part of a preventive health visit.	No charge if performed as part of a preventive health visit costing less than $1,500.	Age and frequency schedules may apply. See vision plan for additional coverage options.
	Children's glasses	Not covered	Not covered	See vision plan for additional coverage options.
	Children's dental check-up	Not covered	Not covered	See dental plan for additional coverage options.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Glasses
- Private Duty Nursing
- Hearing aids
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (if medically necessary or in lieu of anesthesia)
- Bariatric surgery (pre-authorization required)
- Chiropractic care
- Infertility treatment (includes artificial insemination and in-vitro fertilization up to $10,000 lifetime maximum)
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also

provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact hr.conocophillips.com or call 1-800-622-5501. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gove/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-662-5501.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-622-5501.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-622-5501.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-622-5501.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,730**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$1,930
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,990**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$840
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,900**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,930**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,930
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,930**

The plan would be responsible for the other costs of these EXAMPLE covered services.