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2024 U.S. Inpatriate Benefit Highlights

*Note: Changes for 2024 are shown in **bold**.*

	Network (In the U.S.)	Non-Network (In the U.S.)	Outside the U.S.
Cost Sharing			
Annual deductible	None	**$3,200** You Only **$6,400** Other coverage levels	None
Out-of-pocket maximum	$4,000 You Only $8,000 Other coverage levels	$8,000 You Only $16,000 Other coverage levels	None
Lifetime coverage limit	No limit	No limit	No limit
Medical Services			
Preventive Care	100% covered	60% covered after deductible	100% covered
Office visits	100% covered	60% covered after deductible	100% covered
Inpatient and Outpatient Services	100% covered	60% covered after deductible	100% covered
Emergency room	100% covered	100% covered	100% covered
Hearing Aids Maximum: 1 aid per ear every 36 months up to $1,000	100% covered	60% covered after deductible	100% covered
Infertility Treatment	100% covered for facility; 80% covered for office visit and testing	60% covered after deductible	100% covered
Mental Health & Substance Use Disorder Services	100% covered	60% covered after deductible	100% covered
Speech Therapy	100% covered	60% covered after deductible	100% covered

Prescription Drugs			
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.			
Retail Pharmacy | Home Deliver – 30- or 90-day supplies			
	Network (In the U.S.)	Non-Network (In the U.S.)	Outside the U.S.
Generic	80% covered	60% covered, deductible not applicable	100% covered
*Brand Name	80% covered	60% covered, deductible not applicable	100% covered

**Home delivery prescription drug coverage is only available via in-network pharmacies.*

Dental Services	
Annual Deductible	N/A
Class 1: Diagnostic and Preventive Services	100% covered
Class 2: Basic Services	80% covered
Class 3: Major Services	50% covered
Class 4: Orthodontia	50% covered $2,000 per person lifetime maximum benefit
Class 5: Implants	50% covered
Plan Limits	
Annual maximum benefit	$2,000 per person (combined for Classes 1, 2, 3 and 5)

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Vision	
Annual Eye Exam	100% covered; 1 per dependent per calendar year
Annual Hardware Allowance	$200 per person; 1 pair of glasses or contact lenses per calendar year

Note: This is not evidence of coverage. You must enroll and be accepted for coverage with the Plan Administrator before these documents will be effective. In the case of a discrepancy between the Plan Documents and this document, the Plan Documents will determine the Plan Benefits. As used herein, the term “Plan Documents” includes, but is not limited to, the Booklet, Summary of Coverage and any Booklet Amendments/Riders including any state-specific variations, as applicable. For further details, refer to your Plan Documents.

These comparisons provide an overview of certain terms and conditions of the health and welfare benefits and are for information purposes only. Benefits and eligibility for coverage are determined under the specific provisions of the official plan documents and any underlying insurance contracts. If there is any discrepancy or conflict between these highlights and the terms of the official plan documents and any underlying insurance contracts, as applicable, the official plan documents and insurance contracts, as applicable, will control. ConocoPhillips reserves the right to amend, change or terminate the health and welfare benefit plans, any underlying contracts or any other programs, at any time and without notice, at its sole discretion, according to the terms of the applicable plans or programs.