



2025 Employee Benefits Handbook

Effective January 1, 2025

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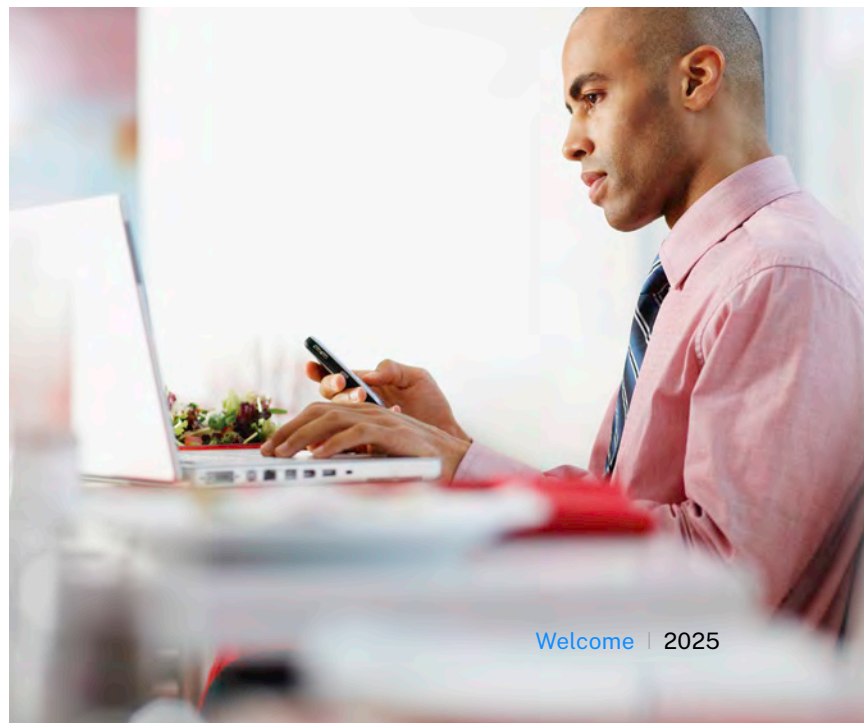
This handbook is the Summary Plan Description (SPD) for the ConocoPhillips health and welfare plans. Additionally, if you are enrolled in a plan that’s insured and provides you an insurance contract and Certificate of Coverage, that insurance contract and the Certificate of Coverage will be considered a part of the SPD for that insured plan. When you enroll you will receive information about how to access the current cost for most of the plans described in this handbook. That information and any Summaries of Material Modifications that are issued should be maintained with this handbook. If you are enrolled in a plan that’s insured by an insurance contract, sections of this handbook that do not apply to you will be indicated. Some employees are not eligible to participate in the plans described in this handbook. Receipt of this handbook does not mean you are eligible to participate in all the plans described. To be eligible to participate in a particular plan, you must meet the eligibility requirements outlined for that plan. This handbook does not describe health and welfare benefits for retired employees. Every effort has been made to ensure the accuracy of this handbook. If there is any conflict between this handbook and the official plan documents, the official plan documents will control. If an insurance contract exists, it is part of the official plan document and will control. Nothing in this handbook creates an employment contract between ConocoPhillips Company or its subsidiaries and affiliates and any employee. The Company reserves the right to amend or terminate a plan at any time, in its sole discretion, according to the terms of the plan.



Welcome to the ConocoPhillips Employee Benefits Handbook



ConocoPhillips is committed to your overall health and well-being, and we're pleased to offer a quality, competitive benefits package that provides valuable health care and financial protection for you and your family.

Your benefits are a significant part of your total compensation at ConocoPhillips, and it's your responsibility to make sure you understand them and use them wisely. This easy-to-use handbook, which features important information about our health and welfare benefit plans, is designed to help you do just that.



Features to Help You

Within the handbook, you'll find features to help increase your understanding of the benefit plan being described. These features include:

- **Examples** — We've included several examples of your benefits at work. As you see your benefits "in action," you'll get a working understanding of the mechanics of your ConocoPhillips benefit plans and how they might apply to you.
- **Icons** — The following icons placed throughout the text highlights essential information for you:
 -  Refers you to other sections in the handbook that provide additional information on the subject.
 -  Highlights information of special importance.
- **Contacts** — For easy reference, this chapter, located at the front of the handbook, provides you with the phone numbers, addresses, and websites for benefit plan resources when you have questions or need contact information.
- **Glossary** — Some benefit terms used in this handbook have very specific meanings. These terms are underlined throughout this book, and you'll find their definitions in the "Glossary" at the end of the handbook.

Staying Up to Date

The benefit information in this handbook will be updated from time-to-time, as necessary. When that happens, you'll receive a notice of what's changing and when. Be sure to keep any updates with this handbook for easy access.

Additional information about your ConocoPhillips benefits is available on hr.conocophillips.com.



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Health and Welfare Plans

Plan Administration



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<ul style="list-style-type: none"> • Eligibility criteria to participate in a health and welfare plan • Enrollment, changing coverage • Changing personal information (including dependent information) • Coverage amounts • Payment of premiums • Qualified Medical Child Support Orders (QMCSO) • Company HSA contribution 	Benefits Center P.O. Box 770 Monroe, WI 53566-0770 Web: <ul style="list-style-type: none"> • Visit hr.conocophillips.com to see benefit plan information • Visit Workday (for active employees only), or at http://hr.conocophillips.com/contacts-resources/mybenefits for personal and benefit plan information and enrollments 	(800) 622-5501 or (718) 354-1344 7:00 a.m. to 7:00 p.m. Central time, Monday – Friday
<ul style="list-style-type: none"> • Accessing Workday, your logon ID, password or Web access code 	http://themark.cop.com or https://www.myworkday.com/conocophillips/login-saml2.flex	Americas Service Desk (918) 661-4095 or (866) 322-2825 24 hours/day, 365 days/year Europe/Middle East/Africa Service Desk +47-52-02-2222 24 hours/day, 365 days/year Asia/Pacific Service Desk +61-7-3182-7000 24 hours/day, 365 days/year

COBRA Administration

For Information on:	Contact/Address	Phone/Operating Hours
Continuing your medical, vision, dental, Employee Assistance Plan and Flexible Spending Plan's Health Care Flexible Spending Account	Benefits Center P.O. Box 770 Monroe, WI 53566-0770 Web: <ul style="list-style-type: none"> • Visit hr.conocophillips.com to see benefit plan information • Visit http://mybenefits.conocophillips.com for personal and benefit plan information and enrollments 	(800) 622-5501 or (718) 354-1344 7:00 a.m. to 7:00 p.m. Central time, Monday – Friday Fax: (515) 273-1545

Claims and Services

The Plans described in this Summary Plan Description (SPD) have a Benefits Committee that has delegated certain responsibilities to others, which may include the administration of claims. Contact information provided below identifies others who have been delegated authority to assist you with your participation in the Plans, including the filing of claims.

- See the “How to File a Claim” section in each of the health and welfare benefit plan chapters for details on filing a benefit claim.
- See the information in this section for the Claims Administrators and their contact information.
- See “Claims and Appeals Procedures” for information on how to appeal a denied claim and for the Appeals Administrators’ contact information.
 “Claims and Appeals Procedures,” page N-26
- See “Plan Administration” for descriptions of the Benefits Committee’s rights and responsibilities and its contact information.
 “Plan Administration,” page N-4

For Information on:	Contact/Address	Phone/Operating Hours
Medical and Prescription Drug		
You should contact the appropriate parties identified below if you have questions about:		
<ul style="list-style-type: none"> • Network providers • Covered and non-covered expenses • ID cards • Claims • Network deficiency 		
Medical Benefits (Blue Choice PPO network)	Blue Cross and Blue Shield of Texas Medical Claims Administrator P.O. Box 660044 Dallas, TX 75266-0044 Web: hr.conocophillips.com or www.bcbstx.com Blue Access for Members (BAM) <i>(for self-service)</i> Blue Distinction Centers <i>(for transplants, cardiac, orthopedic, bariatric procedures)</i> Well-Being Management <i>(health-management service on complex conditions to lifelong wellness)</i> Blue365™ <i>(access to health & wellness products/services)</i> Network Deficiency <i>(medical network provider not available)</i>	(800) 343-4709 7:00 a.m. to 9:00 p.m. Central time, Monday – Friday (calls will be routed for after-hour services)
	MDLive <i>(for physician telephone medical consultation)</i> Web: https://members.mdlive.com/bcbstx	(888) 680-8646 24 hours/day, 365 days/year
	2nd MD <i>(for medical second opinions)</i> Web: www.2nd.md/conocophillips	(866) 841-2575 7:00 a.m. to 7:00 p.m. Central time, Monday – Friday
	Nurseline	(800) 581-0368 24 hours/day, 365 days/year
	Blue Card/Global Core <i>(for traveling outside the U.S.)</i> Web: bcbsglobalcore.com	(800) 810-2583 24 hours/day, 365 days/year <i>Outside the U.S.:</i> (804) 673-1177 (call collect) 24 hours/day, 365 days/year

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For Information on:	Contact/Address	Phone/Operating Hours
Health Improvement Programs (Biometric Screenings)	Quest Diagnostics Web: www.questforhealth.com	(855) 623-9355 7:00 a.m. to 7:00 p.m. Central time, Monday – Friday 7:30 a.m. to 2:00 p.m. Central time, Saturday
Medical, Prescription Drug, Dental, Mental Health and Substance Use Disorder Benefits <i>(Only employees eligible for the U.S. Inpatient Medical and Dental Plan or the Expatriate Medical and Dental Plan)</i>	Cigna Global Health Benefits Claims Administrator P.O. Box 15050 Wilmington, DE 19850-5050 Web: www.cignaenvoy.com	<i>Within the U.S.:</i> (855) 611-8130 24 hours/day, 365 days/year <i>Outside the U.S.:</i> (302) 797-5252 (call collect) 24 hours/day, 365 days/year <i>Fax:</i> (800) 243-6998 (302) 797-3150 (direct)
Prescription Drug Benefits	CVS Caremark™ Claims Administrator P.O. Box 52136 Phoenix, AZ 85072-2136 Web: hr.conocophillips.com or www.caremark.com or www.cvsspecialty.com	(855) 293-4118 24 hours/day, 365 days/year <i>For Specialty Pharmacy:</i> (800) 237-2767 6:30 a.m. to 8:00 p.m. Central time, Monday – Friday <i>For ExtraCare Health Card:</i> (888) 543-5938 9:00 a.m. to 9:00 p.m. Eastern time, Monday – Friday 10:00 a.m. to 6:30 p.m. Eastern time, Saturday – Sunday
Prescription Drug Network Deficiency	ConocoPhillips Company Benefits Committee P.O. Box 4783 Houston, TX 77210	(918) 661-5381 or (877) 812-7547 8:00 a.m. to 5:00 p.m. Central time, Monday – Friday <i>Fax:</i> (918) 662-3455
Vision		
Vision Benefits	Vision Service Plan Insurance Company Claims Administrator 3333 Quality Drive Rancho Cordova, CA 95670 Web: www.vsp.com <i>For non-network provider claims only:</i> P.O. Box 495918 Cincinnati, OH 45249-59	(800) 877-7195 8:00 a.m. to 7:00 p.m. Central time, Monday – Saturday
Hearing Aid Discount <i>(Vision Plan enrollees only)</i>	TruHearing, Inc. Claims Administrator 9071 S. 1300 West #100 West Jordan, UT 84088 Web: https://www.truhearing.com/vsp	(877) 396-7194 8:00 a.m. to 8:00 p.m. Central time, Monday – Friday

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For Information on:	Contact/Address	Phone/Operating Hours
Onsite Medical Clinics		
<ul style="list-style-type: none"> • Clinic services • Appointments • Costs 	Houston Onsite Medical Clinic 925 N. Eldridge Pkwy Suite E-C4-1-N353 Houston, TX 77079 Web: hr.conocophillips.com	(713) 984-6650 7:00 a.m. to 4:00 p.m. Central time, Monday – Thursday
	The Well Onsite Medical Clinic 600 W. Illinois Ave. Midland, TX 79701 Web: hr.conocophillips.com	(432) 221-0400 8:00 a.m. to 5:00 p.m. Central time, Monday and Wednesday 9:00 a.m. to 6:00 p.m. Central time, Tuesday and Thursday 8:00 a.m. to 12:00 p.m. Central time, Friday
	The Well Onsite Medical Clinic 2208 W. Main Artesia, NM 88210 Web: hr.conocophillips.com	(575) 748-1599 7:00 a.m. to 3:30 p.m. (closed 11:30 a.m. to 12:00 p.m.) Central time, Monday and Wednesday 7:00 a.m. to 5:30 p.m. (closed 11:30 a.m. to 12:00 p.m.) Central time, Tuesday and Thursday 7:00 a.m. to 11:00 a.m. Central time, Friday
Dental		
Dental Benefits <ul style="list-style-type: none"> • Network providers • Covered and non-covered expenses • Claims • Predeterminations 	MetLife ConocoPhillips Dental Claims Administrator P.O. Box 981282 El Paso, TX 79998-1282 Web: hr.conocophillips.com or www.metlife.com/mybenefits Email: cpdental@metlife.com	(888) 328-2166 8:00 a.m. to 11:00 p.m. Eastern time, Monday – Friday <i>For International Dental Travel Assistance dentist referral:</i> (888) 558-2704 or (312) 356-5970 24 hours/day, 365 days/year
Flexible Spending Plan (FSP)		
Health Care Flexible Spending Account and Dependent Care Flexible Spending Account Benefits <ul style="list-style-type: none"> • Reimbursement requests (claims) • Account balance • Eligible expenses • Order FSA debit cards for spouse/dependents 	Inspira Financial Claims Administrator P.O. Box 4000 Richmond, KY 40476-4000 Web: www.inspirafinancial.com	(888) 678-8242 7:00 a.m. to 7:00 p.m. Central time, Monday – Friday 9:00 a.m. to 2:00 p.m. Central time, Saturday TTY/TDD: (877) 703-5572 Fax: (888) 238-3539

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For Information on:	Contact/Address	Phone/Operating Hours
Disability		
Short-Term Disability		
<ul style="list-style-type: none"> Plan provisions 	HR Connections P.O. Box 5555 Bartlesville, OK 74005-5555 Web: hr.conocophillips.com	(877) 81-ASK HR [(877) 812-7547] or (918) 661-5381 8:00 a.m. to 5:00 p.m. Central time, Monday – Friday
<ul style="list-style-type: none"> Claim denial or reduction 	Benefits Committee STD Claims Administrator P.O. Box 4783 Houston, TX 77210	(918) 661-5381 or (877) 812-7547 8:00 a.m. to 5:00 p.m. Central time, Monday – Friday
<ul style="list-style-type: none"> Employee Health Report (EHR) Return to Work Releases 	HR Connections or Email: healthservices@conocophillips.com or Contact your local designated Health Services (medical) representative	(877) 81-ASK HR [(877) 812-7547] or (918) 661-5381 8:00 a.m. to 5:00 p.m. Central time Monday – Friday Fax: (918) 662-6873
Long-Term Disability		
<ul style="list-style-type: none"> Claim filing Coverage questions 	Benefits Center P.O. Box 770 Monroe, WI 53566-0770 Web: <ul style="list-style-type: none"> Visit hr.conocophillips.com to see benefit plan information Visit Workday (for active employees only), or at http://hr.conocophillips.com/contacts-resources/mybenefits for personal and benefit plan information and enrollments 	(800) 622-5501 or (718) 354-1344 7:00 a.m. to 7:00 p.m. Central time, Monday – Friday
<ul style="list-style-type: none"> Questions after claim filing (if first day of elimination period is Jan. 1, 2020 or after) 	The Hartford P.O. Box 14869 Lexington, KY 40512 Web: www.abilityadvantage.thehartford.com	(888) 301-5615 8:00 a.m. to 8:00 p.m. Eastern time, Monday – Friday Fax: (833) 357-5153
<ul style="list-style-type: none"> Questions after claim filing (if first day of elimination period is Dec. 31, 2019 or before) 	MetLife Disability Claims Administrator P.O. Box 14590 Lexington, KY 40511-4590	(800) 638-2242 8:00 a.m. to 11:00 p.m. Eastern time, Monday – Friday

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For Information on:	Contact/Address	Phone/Operating Hours
Life and Accidental Death and Dismemberment (AD&D)		
Life <ul style="list-style-type: none"> • Claim filing (n/a to OAD or Travel Assistance) • Coverage questions • Beneficiary designations 	Benefits Center P.O. Box 770 Monroe, WI 53566-0770 Web: <ul style="list-style-type: none"> • Visit hr.conocophillips.com to see benefit plan information • Visit Workday (for active employees only), or at http://hr.conocophillips.com/contacts-resources/mybenefits for personal and benefit plan information and enrollments 	(800) 622-5501 or (718) 354-1344 7:00 a.m. to 7:00 p.m. Central time, Monday – Friday
<ul style="list-style-type: none"> • Questions after a claim has been paid or denied (n/a to OAD or Travel Assistance) 	The Hartford Group Life Claims Administrator Maitland Claims Office P.O. Box 14299 Lexington, KY 40512-4299	(888) 563-1124 8:00 a.m. to 8:00 p.m. Eastern time, Monday – Friday <i>Fax:</i> (866) 954-2621
<ul style="list-style-type: none"> • Portability and conversion coverage administration (n/a to OAD or Travel Assistance) 	The Hartford Portability and Conversion Unit P.O. Box 248108 Cleveland, OH 44124-8108	(877) 320-0484 9:00 a.m. to 5:00 p.m. Eastern time, Monday – Friday <i>Fax:</i> (440) 646-9339
<ul style="list-style-type: none"> • Occupational Accidental Death (OAD) claim filing 	Benefits Committee OAD Claims Administrator P.O. Box 4783 Houston, TX 77210	(918) 661-5381 or (877) 812-7547 8:00 a.m. to 5:00 p.m. Central time, Monday – Friday
<ul style="list-style-type: none"> • Travel assistance (part of the Basic Life Insurance option) – Coverage questions 	Generali Global Assistance 4330 East West Highway Suite 1000 Bethesda, MD 20814	<i>Within the U.S. and Canada:</i> (800) 243-6108 24 hours/day, 365 days/year <i>Outside the U.S. and Canada:</i> (202) 828-5885 (call collect) <i>Fax:</i> (202) 331-1528 <i>ID Number:</i> GLD-09012
Accidental Death and Dismemberment (AD&D) <ul style="list-style-type: none"> • Claim filing • Coverage questions • Beneficiary designations 	Benefits Center P.O. Box 770 Monroe, WI 53566-0770 Web: <ul style="list-style-type: none"> • Visit hr.conocophillips.com to see benefit plan information • Visit Workday (for active employees only), or at http://hr.conocophillips.com/contacts-resources/mybenefits for personal and benefit plan information and enrollments 	(800) 622-5501 or (718) 354-1344 7:00 a.m. to 7:00 p.m. Central time, Monday – Friday

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For Information on:	Contact/Address	Phone/Operating Hours
<ul style="list-style-type: none"> Questions after a claim has been paid or denied 	The Hartford Group AD&D Claims Administrator Maitland Claims Office P.O. Box 14299 Lexington, KY 40512-4299	(888) 563-1124 8:00 a.m. to 8:00 p.m. Eastern time, Monday – Friday Fax: (866) 954-2621
<ul style="list-style-type: none"> Conversion coverage administration 	The Hartford Portability and Conversion Unit P.O. Box 248108 Cleveland, OH 44124-8108	(877) 320-0484 9:00 a.m. to 5:00 p.m. Eastern time, Monday – Friday Fax: (440) 646-9339
Employee Assistance Plan (EAP)		
EAP <ul style="list-style-type: none"> Claim filing Coverage questions Access resources 	Concern 2490 Hospital Dr., Suite 310 Mountain View, CA 94040 Email: info@concernhealth.com Self-guided resources: https://employees.concernhealth.com (Enter Company Code = ConocoPhillips)	Within the U.S.: (800) 344-4222 24 hours/day, 365 days/year
EAP <ul style="list-style-type: none"> Claim filing Coverage questions Access resources (Only employees eligible for the U.S. Inpatient Medical and Dental Plan or the Expatriate Medical and Dental Plan)	TELUS Health Claims Administrator 134 N. Lasalle St. #2200 Chicago, IL 60602 Web: one.telushealth.com	Within the U.S.: (888) 509-5560 24 hours/day, 365 days/year Outside the U.S.: See hr.cop.com for the various country phone numbers
Severance Pay		
<ul style="list-style-type: none"> Plan provisions 	HR Connections P.O. Box 5555 Bartlesville, OK 74005-5555 Web: hr.conocophillips.com	(877) 81-ASK HR [(877) 812-7547] or (918) 661-5381 8:00 a.m. to 5:00 p.m. Central time, Monday – Friday
<ul style="list-style-type: none"> Benefit claims 	ConocoPhillips Company Benefits Committee Severance Pay Plan Claims Administrator P.O. Box 4783 Houston, TX 77210	(918) 661-5381 or (877) 812-7547 8:00 a.m. to 5:00 p.m. Central time, Monday – Friday Fax: (918) 662-3455

Family Life Benefits Plan

For Information on:	Contact/Address	Phone/Operating Hours
<ul style="list-style-type: none"> • Services • Costs • Facility locations 	<p>The Play Child-Care Center 505 N. Pecos St. Midland, TX 79701 Web: www.brighthorizons.com/theplay</p> <p>Back-Up Care Web: www.brighthorizons.com/family-solutions/back-up-care</p>	<p>(432) 688-6698 7:00 a.m. to 6:00 p.m. Central time, Monday – Friday</p> <p>(877) BH-CARES [(877) 242-2737] 24 hours/day, 365 days/year</p>

Employee Medical Plan

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✓ Please refer to the Glossary beginning on page O-1 for the definitions of underlined terms used throughout this SPD.

📖 “Glossary,” page O-1

In this chapter, the term “Company” is used to describe ConocoPhillips and the other companies whose employees are covered by this Plan.

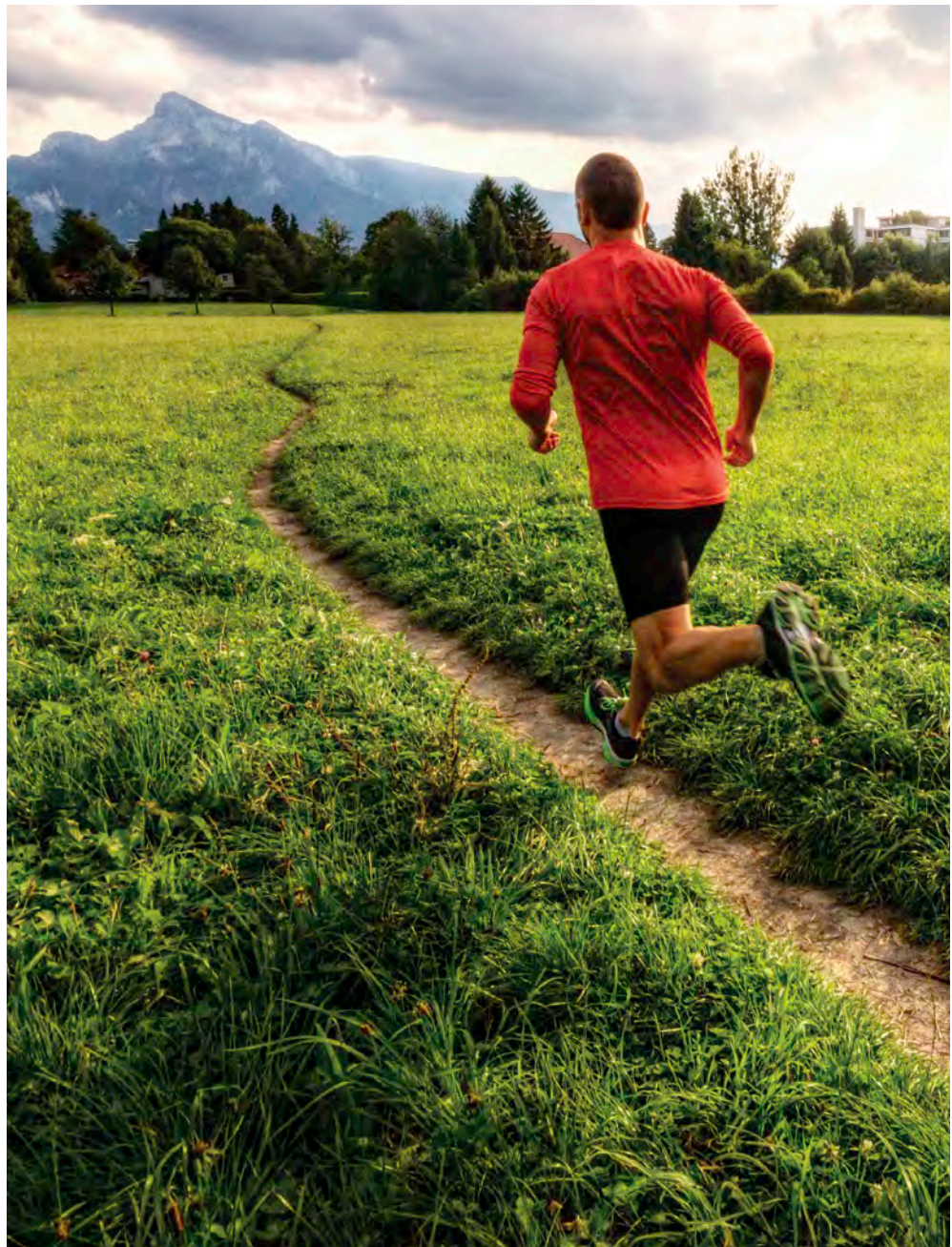
✓ For information on retiree or survivor medical benefits, refer to the separate *Retiree Benefits Handbook* available from the Benefits Center or on hr.conocophillips.com.

Introduction

The ConocoPhillips Employee Medical Plan (the Plan) provides you and your family with important protection against the financial hardship that often accompanies illness or injury. The Plan has been designed to provide medical coverage for you and your family at a competitive cost.

You may be eligible for the following medical options:


- The High Deductible Health Plan (HDHP) option; and
- The High Deductible Health Plan Base (HDHP Base) option.



Who Is Eligible

EMPLOYEES ELIGIBLE FOR THE EXPATRIATE MEDICAL AND DENTAL PLAN

Employees eligible for the Expatriate Medical and Dental Plan **are not** eligible for the Employee Medical Plan (except some are eligible for the U.S. Health Improvement Incentive Program provisions of the Employee Medical Plan).

 “U.S. Health Improvement Incentive Program,” page B-46.

Employee Eligibility

If you're an **active, regular full-time or regular part-time¹ employee**, you're eligible to participate in the Plan if you're:


- A U.S. citizen or resident alien employee working within the U.S. (includes rotators) who is paid on the direct U.S. dollar payroll²; or
- A U.S. citizen or resident alien employee working within the U.S. (includes rotators) who is paid on the direct U.S. dollar payroll² and who is on a personal, disability or military leave of absence or on a family medical leave of absence or is an under-age-65 heritage Tosco former employee receiving long-term disability benefits with eligibility designated on Company records.
- An employee who is eligible for the Expatriate Medical and Dental Plan is eligible **only** for the U.S. Health Improvement Incentive Program and related provisions of this Plan.

You're **not** eligible to participate in the Plan if your classification isn't described in this section. For example, temporary employees, intermittent employees, independent contractors, contingent workers, contract workers, leased employees and commission agents aren't eligible for the Plan.

¹ Regular part-time employees must be regularly scheduled to work on average at least 20 hours per week.

² Direct U.S. dollar payroll means that payroll check is written in U.S. dollars by a U.S. company participating in the Plan and is not converted to another currency before being paid to the employee.

Note: Special rules apply if your spouse/domestic partner is also a Company employee or retiree.

 “If Your Eligible Dependent Is Also a Company Employee or Retiree,” below

-
- ✓ Contact the Benefits Center for questions about whether your collective bargaining agreement expressly provides for your participation in the Plan.

 “Contacts,” page A-1

If Your Eligible Dependent Is Also a Company Employee or Retiree

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- ✓ Review the rules used in determining dependent eligibility under the Plan.

 “Dependent Eligibility,” page B-6

If you have an eligible dependent (spouse/domestic partner, dependent child) who is also **employed by or a retiree of ConocoPhillips**, neither you nor any eligible dependent can be covered by more than one Company medical plan, including COBRA, but excluding the Retiree Medical Age 65 and Over Plan. Dual coverage is prohibited even if the other medical option is union-sponsored medical coverage.

If both you and your spouse/domestic partner are employed by ConocoPhillips, your election is considered to be a separate election from your spouse's/domestic partner's election and cannot be changed during the calendar year unless a change in status occurs (e.g., you get divorced, gain or lose a dependent, change in job status, etc.).

 “Changing or Cancelling Your Coverage,” page B-9

- ✓ If you are not a U.S. citizen or a resident alien or if you have a dependent who is not a U.S. citizen, resident alien, a resident of Canada or a resident of Mexico, you may elect to enroll yourself and your dependents in the ConocoPhillips Expatriate Medical and Dental Plan.
-

Dependent Eligibility

- ✓ If an eligible dependent has other medical coverage (in addition to coverage under this Plan), refer to this Plan's coordination of benefits (COB) provisions.

 "Coordination of Benefits (COB)," page B-48

If you enroll in the Plan, your eligible dependents may also be enrolled for coverage. Eligible dependents include your:

- Spouse (including your state-recognized common-law spouse¹; excluding a spouse after a divorce or separation by a legal separation agreement²) or your domestic partner; and
- Child, as follows:
 - Your biological, legally adopted (includes foreign adoptions) or placed for adoption child;
 - Your domestic partner's biological or legally adopted child (includes foreign adoptions), provided the child receives over 50% of his or her support from you and has the same principal place of abode as you for the tax year;
 - Your child under a legal guardianship agreement issued by a court; or
 - Your stepchild, provided the parent is your spouse and you and your spouse either remain married and reside in the same household or your spouse died while married to you.

You can cover the child/stepchild/guardianship child/domestic partner's child if he or she is:

- Under age 26³; or
- Age 26 or older, provided the child was disabled prior to age 26 and coverage is approved by the Plan within 30 calendar days of his or her reaching age 26 or initial eligibility after age 26⁴.

¹ The common-law marriage must be consummated in a state that recognizes common-law marriage, and all state requirements must have been met.

² The Plan will recognize a decree of legal separation or court-approved legal written separation agreement of any kind — including a court-approved separate maintenance agreement.

³ Your child is considered an eligible dependent up to age 26 regardless of student status, marital status, employment status and/or IRS dependent requirements.

⁴ A disabled dependent over age 26 who is disabled prior to age 26 may enroll in the Plan (i) during annual enrollment or (ii) if such disabled dependent experiences a qualified change in status.

Note: A dependent is **not** eligible if he or she:

- Is on active duty in any military service of any country (excluding weekend duty or summer encampments);
- Is not a U.S. citizen, resident alien or resident of Canada or Mexico;
- Is already covered under a Company medical plan as an employee, retiree or as a dependent of either (including COBRA participants and excluding the Retiree Medical Age 65 and Over Plan);
- Is the child of a domestic partner and has been claimed as a dependent on your domestic partner's or on anybody else's federal tax return for the year of coverage;
- Is the child of a domestic partner and the domestic partnership between you and your domestic partner has ended, even if your domestic partner's child continues to reside with you;
- Is the child of a surrogate mother (is not considered the child of the egg donor) and does not qualify as a dependent otherwise;
- Is no longer your stepchild due to divorce, legal separation or annulment;
- Is a grandchild not legally adopted by you;
- Is placed in your home as a foster child; or
- Is in a relationship with you that violates local law.


Dependent Certification Rules

When you enroll your eligible dependent(s) in the Plan and when you continue their participation at each annual enrollment, you represent the following:

- The individual is eligible under the terms of the Plan; and
- You will provide evidence of eligibility on request.

Enrolling an ineligible dependent **or** not cancelling coverage within 30 calendar days of when an eligible dependent ceases to meet the Plan's dependent eligibility requirements **or** failure to provide required evidence of eligibility is considered by the Plan to be evidence of fraud and intentional misrepresentation of a material fact that will trigger rescission that may be back to the date on which your dependent no longer qualifies as an eligible dependent. If the coverage is rescinded, the Plan will give the participant a 30-calendar-day advance written notice prior to rescission. The Plan has the right to request reimbursement of any claims or expenses paid for an ineligible dependent. If canceling your ineligible dependent's coverage reduces your cost for coverage, any amounts you have overpaid will not be refunded. In addition, you may be subject to disciplinary action — up to and including termination of coverage for benefits in the applicable Plan or termination of employment by the employer for enrolling or keeping an ineligible dependent in the Plan.

Proof documenting dependent eligibility must be provided per rules, which may include requirements for self certification in addition to documentation, adopted by the Benefits Committee. Failure to provide the certification and/or the requested documents verifying proof of dependent eligibility in a timely manner may delay or prevent your dependent's coverage, and you generally will not be able to enroll in coverage until the next annual enrollment period unless you experience a change in status event described in the "Changing Your Coverage" section. If coverage is added at a later date, you will once again be asked to provide the appropriate documentation of dependent status. Contact the Benefits Center for details or if you have any questions about this requirement.

 "Contacts," page A-1; "Changing or Cancelling Your Coverage," page B-9

If You or a Dependent Becomes Eligible for Medicare

✓ See "Coordination With Medicare" for further information.

 "Coordination With Medicare," page B-49

If you enroll in a medical option, you must notify the Benefits Center and provide a copy of your Medicare card within 30 calendar days if you or an eligible dependent becomes eligible for Medicare coverage due to age, Social Security disability or end-stage renal disease before age 65. The Benefits Center will explain how your Medicare elections may impact your coverage in the Plan, as well as your ability to continue HSA contributions.

 "Contacts," page A-1

If the Benefits Center isn't notified within this 30-day period, any medical claims that were processed by the Plan without Medicare payment information may be reprocessed. If it's then determined that the claim was overpaid, you'll be required to reimburse the Plan for any overpayment you received.

If you're an active employee, and you continue to work past your eligibility date for Medicare benefits, or if you and/or a dependent become eligible for Medicare, you and/or the dependent can:

- Defer Medicare enrollment and continue any option of medical coverage under this Plan until the date your employment ends or your dependent ceases to qualify as an eligible dependent under the Plan.
- Elect to enroll in Medicare and continue any option of medical coverage under this Plan — with the Plan as the primary coverage and Medicare as the secondary coverage — until the date your employment ends or your dependent ceases to qualify as an eligible dependent under the Plan.
- Elect Medicare as the primary coverage and cancel coverage under the medical option. If you are the one eligible for and elect Medicare as primary coverage, coverage for your eligible dependents will end also. If the person eligible for Medicare enrolls in Medicare Part D or Medicare Part C with prescription coverage, their coverage under this Plan will be cancelled.

See "Coordination of Benefits (COB)" for information on primary and secondary coverage.

 "Coordination of Benefits (COB)," page B-48

- ✓ If you or your eligible dependent becomes eligible for Medicare, it's your responsibility to contact Medicare regarding eligibility, enrollment and penalties for late Medicare enrollment.

How to Enroll, Change or Cancel Coverage

If you want to enroll in medical coverage for yourself or your eligible dependents, you may enroll online or call the Benefits Center. Your enrollment materials will contain information to help you make your enrollment elections. If you have questions about the enrollment procedure or need more information, contact the Benefits Center.

 “Contacts,” page A-1

When you enroll, you’ll:

- Choose from the Plan options available to you;
- Decide which of your eligible dependents you wish to cover, if any; and
- Authorize any required payroll deductions for the cost of the coverage you select.

✓ Your medical, vision and dental enrollment elections are separate — meaning you can enroll for medical coverage regardless of whether you’re enrolled in vision or dental coverage, and vice versa. In the same way, you can choose to enroll different eligible dependents in your medical coverage than in your vision or dental coverage.

✓ Medical/Prescription Drug ID Cards

The Claims Administrators for medical and for prescription drug benefits issue temporary, original and replacement ID cards.

 “Contacts,” page A-1

When to Enroll, Change or Cancel Coverage

You can enroll, change or cancel Plan coverage:

- When you become eligible as a new employee;
- When you become eligible due to a change in your employee classification;
- During annual enrollment; or
- If you have a change in status.

 “Changing or Cancelling Your Coverage,” page B-9

HIPAA SPECIAL ENROLLMENT

(Applies only to enrollment in medical coverage and premium payment under the Flexible Spending Premium Account for that coverage)

If you are declining enrollment for yourself or your eligible dependents (including your spouse/domestic partner) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and your eligible dependents in the Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage and you can no longer afford the coverage). However, you must request enrollment within 30 calendar days after your or your dependents’ coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new eligible dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents. However, you must request enrollment within 30 calendar days after the marriage, or within 90 calendar days after a birth, adoption or placement for adoption.

Also, you must request enrollment within 60 calendar days of when you or your eligible dependent loses eligibility for Medicaid or State Children’s Health Insurance Program (SCHIP), or when you or your eligible dependent becomes eligible for a premium assistance subsidy under Medicaid or SCHIP.

To request special enrollment or obtain more information, contact the Benefits Center.

 “Contacts,” page A-1

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- ✓ After your initial eligibility for the Plan, you can enroll only during annual enrollment unless you have a change in status during the year. A disabled dependent over age 26 who is disabled prior to age 26 may enroll in the Plan (i) during annual enrollment or (ii) if such disabled dependent experiences a qualified changed in status.
-

When Coverage Begins

The date coverage for you and/or your eligible dependents begins depends on the event and on when you enroll.

For the following event:	If an enrollment action is made with the Benefits Center:	The coverage change effective date is:
Employees newly hired or newly eligible to participate	Within 30 calendar days after the event ¹	The date of the event
Annual enrollment	Within the annual enrollment period	The following Jan. 1
When you have a change in status	See “Changing Your Coverage” below for information	See “Changing Your Coverage” below for information
When you add a new <u>eligible dependent</u> due to birth, adoption or <u>placement for adoption</u>	Within 90 calendar days after the event ¹	The date of the event
When you return to work as a regular full-time or regular part-time employee on or before the expiration of a <u>leave of absence</u> (if a loss of coverage occurred during the leave)	Within 30 calendar days after the event ¹	The date of the event
When you return to work as a regular full-time or regular part-time employee on or before the expiration of a <u>leave of absence-Labor Dispute</u> (if a loss of coverage occurred during the leave and the leave was 30 calendar days or less)	No enrollment action is required; coverage will be reinstated automatically	The date of the event
When you return to work as a regular full-time or regular part-time employee on or before the expiration of a <u>leave of absence-Labor Dispute</u> (if a loss of coverage occurred during the leave and the leave was more than 30 calendar days)	Within 30 calendar days after the event ¹	The date of the event
When you or your <u>eligible dependent(s)</u> either terminate Medicaid or CHIP (Children’s Health Insurance Program) coverage due to loss of eligibility or become eligible for a state premium assistance program or CHIP with respect to coverage under the law	Within 60 calendar days after the event ¹	The date of the event

¹ If an enrollment action is not made within the allowable number of calendar days after the event, you won’t be able to make the enrollment action until the next annual enrollment period (absent another enrollment event), with coverage effective the first of the following calendar year.

✓ If you’re a surviving spouse/domestic partner or eligible child, see “In the Event of Your Death.”

📄 “In the Event of Your Death,” page B-51

Changing or Cancelling Your Coverage

Because you pay for coverage on a before-tax basis, IRS rules limit when you can make changes to your coverage. Other than during each year’s annual enrollment, you can change your coverage election only if you experience a change in status for which you may be required or allowed to make changes to your coverage. The coverage election must be consistent with your change in status, and you cannot make a coverage change for financial reasons or because a provider stops participating in a network.

Because coverage change effective dates vary based on the event and the date of your enrollment action, contact the Benefits Center for further information about when the coverage change will be effective. If your change is considered a HIPAA Special Enrollment and you change medical options, the effective date will be the birth or marriage date instead of the first of the following month. This could cause coverage provision changes on medical services in process. To make changes, enroll online or call the Benefits Center.

 “Contacts,” page A-1

“Change in status” changes may include these life events:

- Your marriage, divorce, legal separation or annulment;
- Death of an eligible dependent;
- Addition of an eligible dependent through birth, adoption, legal guardianship or placement for adoption. (Even if you already have *You + Children* or *You + Family* coverage, you need to enroll your new eligible dependent(s) in order for their coverage to take effect);
- A relocation or move outside of the U.S. and/or network’s coverage area;
- Loss of coverage;
- A Qualified Medical Child Support Order that requires you to provide medical coverage for a child;
- A change in employment status by you or your eligible dependent;
- A change in work schedule by you or your eligible dependent that changes coverage eligibility;
- A change in your eligible dependent’s status;
- You and/or your eligible dependents become eligible for and enroll in or lose eligibility for Medicare or Medicaid;
- You and/or your eligible dependents become entitled to COBRA;
- The taking of or return from a leave of absence under the Family Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act of 1994; and
- You or your eligible dependents have a significant change in benefits or costs, such as benefits from another employer, etc.

If you don’t report the change to the Benefits Center within 30 calendar days¹ after the event date:


- **You won’t be able to change coverage until the next annual enrollment period; and**
- **The change won’t be effective until the first of the following calendar year.**

¹ This period is extended to 60 or 90 days in a few limited circumstances. See the chart on page B-9.

The calendar-day limit doesn’t apply to change in status events that result in coverage cancellations for you and or your dependent(s). There must be a change in status event that causes ineligibility for coverage and that coverage cancellation can be made at any time. If you fail to cancel coverage on an ineligible dependent, see “Dependent Certification Rules.”

 “Dependent Certification Rules,” page B-6

The Benefits Committee shall have the exclusive authority to determine if you’re entitled to revoke an existing election as a result of a change in status or a change in the cost or coverage, as applicable, and its determination shall bind all persons.


 If a relocation back to the U.S. or a transfer to the U.S. payroll initiates eligibility for this Plan, or if your medical option is eliminated, your coverage will automatically be the HDHP Base option unless you enroll otherwise.

If You Take a Leave of Absence

If you’re on a leave of absence, you may continue coverage for yourself and your dependents during the approved leave period — provided you pay any required costs for coverage when they’re due.

- During your leave, you pay the same cost for coverage that an active employee would pay.
 - If you’re on a paid leave, your cost for coverage will continue to be deducted from your paycheck on a before-tax basis.
 - If you’re not receiving a paycheck from the Company, you’ll pay the cost for coverage to ConocoPhillips on an after-tax basis. (ConocoPhillips will bill you for the cost for coverage.)
- When you return to work, the Company will resume deducting the cost for coverage from your paycheck on a before-tax basis, excluding your HSA contributions. See page B-19 regarding your and the Company HSA contributions during and after your leave of absence.

If you end your coverage while you're away on leave — or if your coverage is ended due to non-payment of required costs for coverage — you must meet the same criteria as an active employee if you want to re-enroll in the Plan upon your return to work.

 “Who Is Eligible,” page B-5; “How to Enroll, Change or Cancel Coverage,” page B-8; “The HDHP and HDHP Base Options and Health Savings Accounts (HSAs),” page B-19

✓ If You're on a Military Leave of Absence

See “USERRA Continuation Coverage” for general information regarding your medical coverage while you're on a military leave of absence.

 “USERRA Continuation Coverage,” page N-20

If You Have a Leave of Absence-Labor Dispute

If you're placed on a leave of absence-Labor Dispute, coverage for you and your dependents will end on the last day of the month in which the leave begins. You may continue coverage for yourself and your dependents during the leave under COBRA provisions. If you're eligible for retiree medical insurance, you may elect that coverage. See the chart on page B-9 for coverage after you return to work. If you are on a leave of absence-Labor Dispute during a regularly scheduled annual enrollment, you won't be eligible and a special annual enrollment period will be provided after you return from the leave of absence-Labor Dispute.

What the Plan Costs


You and the Company share in the cost of medical coverage. Your cost for coverage for yourself and your eligible dependents is based on the Plan option and level of coverage you elect, regardless of your scheduled workweek hours (regular full-time or regular part-time). The cost sharing is designated with Plan eligibility on Company records for an under-age-65 heritage Tosco former employee receiving long-term disability benefits.

Your cost for coverage is automatically deducted from your paycheck on a before-tax basis, which means that your taxable pay is lower — and so is the amount you pay for Social Security and Medicare taxes, federal income tax and, in most areas, state and local income tax. Your enrollment authorizes the deductions to be taken from your paycheck on a before-tax basis. The Benefits Committee reserves the right to recover any underpayments by the employee or eligible dependent, made through error or otherwise, by offsetting future payments, invoicing the affected participant, or by other means as the Benefits Committee deems appropriate.


When you enroll, you'll receive information about how to access the current costs for each of your available Plan options and levels of coverage.

Employee Medical Benefit Highlights

The benefits provided by the medical options are discussed in the chart that begins on page B-12. Additional information on medical expenses covered and not covered by the Plan is included beginning on page B-29. Prescription drug benefits are described beginning on page B-39.

 “Covered Expenses,” page B-29; “Prescription Drug Coverage,” page B-39; “Non-Covered Expenses,” page B-35

✓ The following chart should address most services and treatments. Limitations and exclusions may apply to some services. However, if you have additional questions about a specific treatment or to obtain a predetermination of the benefits that will be paid by the Plan, you should call the Claims Administrator.

 “Contacts,” page A-1; “Predetermination of Benefits,” page B-27


✓ If you're enrolled in the Expatriate Medical and Dental Plan, please refer to the materials provided by the Claims Administrator for information about your coverage.

Plan Provision	HDHP Option: What You Pay		HDHP Base Option: What You Pay	
	Network	Non-Network	Network	Non-Network
<u>Annual Deductible</u> (Employee paid)	\$1,650 if you have <i>You Only</i> coverage ^{1,2,3} \$3,300 for other coverage levels ^{1,2,3}	\$3,300 if you have <i>You Only</i> coverage ^{1,2,3} \$6,600 for other coverage levels ^{1,2,3}	\$3,000 if you have <i>You Only</i> coverage ^{1,2,3} \$6,000 for other coverage levels ^{1,2,3}	\$6,000 if you have <i>You Only</i> coverage ^{1,2,3} \$12,000 for other coverage levels ^{1,2,3}
<u>Annual Out-of-Pocket Maximum</u> (Employee paid)	\$4,000 if you have <i>You Only</i> coverage ^{1,2,3} \$8,000 for other coverage levels ^{1,2,3}	\$8,000 if you have <i>You Only</i> coverage ^{1,2,3} \$16,000 for other coverage levels ^{1,2,3}	\$6,000 if you have <i>You Only</i> coverage ^{1,2,3} \$12,000 for other coverage levels ⁴	\$12,000 if you have <i>You Only</i> coverage ^{1,2,3} \$24,000 for other coverage levels ^{1,2,3}
Preventive Medical Care (Routine Services billed as Preventive)				
<u>Preventive Medical Care Coverage Details</u>	100% covered (per person) network <u>preventive medical care</u> and eligible generic <u>preventive prescription drugs</u> and insulin per calendar year. 100% covered of the first \$1,500 (per person) of non-network <u>preventive medical care</u> per calendar year. After that, benefits are subject to regular Plan benefits.		100% covered (per person) of network <u>preventive medical care</u> per calendar year and 100% covered of the first \$1,500 (per person) of non-network <u>preventive medical care</u> per calendar year. After that, benefits are subject to regular Plan benefits.	
Routine Physical Exams/Well Child Care ⁵	100% covered; no deductible	40%; no deductible	100% covered; no deductible	40%; no deductible
Routine Gynecological Exam ⁵ <i>Includes pap smear</i>	100% covered; no deductible	40%; no deductible	100% covered; no deductible	40%; no deductible
Routine Mammogram ⁵	100% covered; no deductible	40%; no deductible	100% covered; no deductible	40%; no deductible
Routine Prostate Specific Antigen (PSA) ⁵	100% covered; no deductible	40%; no deductible	100% covered; no deductible	40%; no deductible
Routine Colonoscopies ⁵ Routine Sigmoidoscopies ⁵	100% covered; no deductible	40%; no deductible	100% covered; no deductible	40%; no deductible

(continued)

- ✓ References in the chart to the “*You Only*” coverage level are for employee-only, spouse-only or child-only enrollments. References to coverage levels other than “*You Only*” include *You + Child*, *You + Spouse*, *You + Children* and *You + Family* (*You + Spouse + Children*).

¹ All deductibles and out-of-pocket amounts for any family member are equal to that of the option in which you are enrolled, regardless of whether anyone is on Medicare. See the “Annual Deductible” and “Annual Out-of-Pocket Maximum” sections for what charges apply and don’t apply to these annual limits.

 “Annual Deductible,” page B-23; “Annual Out-of-Pocket Maximum,” page B-24

² Expenses applied to the network annual deductible will also apply to non-network annual deductible, and expenses applied to the non-network annual deductible will also apply to network annual deductible. Expenses applied to the network annual out-of-pocket maximum will also apply to non-network annual out-of-pocket maximum, and expenses applied to the non-network annual out-of-pocket maximum will also apply to network annual out-of-pocket maximum.

³ Annual deductible and annual out-of-pocket maximum limits are subject to change depending on cost-of-living adjustments by the IRS for Jan. 1 of each year.





⁴ Once an individual has incurred \$9,200 in eligible network expenses in a calendar year, eligible network claims for that individual will be paid at 100% for the rest of the calendar year regardless of whether the family annual out-of-pocket maximum has been met.

⁵ Includes charges from labs, X-rays, radiologists, anesthesiologists, pathologists, and physicians related to these preventive medical care and non-preventive medical care services. The Claims Administrator may need to be contacted to ensure these ancillary charges are covered per Plan provisions.

Plan Provision	HDHP Option: What You Pay		HDHP Base Option: What You Pay	
	Network	Non-Network	Network	Non-Network
Influenza Vaccine Immunizations	100% covered; no deductible	40%; no deductible	100% covered; no deductible	40%; no deductible
COVID-19 Vaccine Immunizations	100% covered; no deductible	40%; no deductible	100% covered; no deductible	40%; no deductible
<u>Vision Screening</u> Routine Hearing Exams	100% covered; no deductible	40%; no deductible	100% covered; no deductible	40%; no deductible
Preventive Counseling	100% covered; no deductible	40%; no deductible	100% covered; no deductible	40%; no deductible
See hr.conocophillips.com for the Preventive Care Guide with additional information on the most current covered <u>Preventive Medical Care</u> services	100% covered; no deductible	40%; no deductible	100% covered; no deductible	40%; no deductible
Non-Preventive Medical Care Physician Services				
Office Visits	20% after deductible	40% after deductible	20% after deductible	40% after deductible
<u>Walk-In Clinic</u> (non-emergency care)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Surgery (in office)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Surgery (inpatient/ outpatient)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
<u>Physician/Hospital</u> Services	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Second Opinion Office Visit <i>Second opinions aren't required by the Plan</i>	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Radiologists, Anesthesiologists and Pathologists (RAPS)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Diagnostic mammograms and colonoscopies ⁵	100% covered after deductible	40% after deductible	100% covered after deductible	40% after deductible


(continued)

⁵ Includes charges from labs, X-rays, radiologists, anesthesiologists, pathologists, and physicians related to these preventive medical care and non-preventive medical care services. The Claims Administrator may need to be contacted to ensure these ancillary charges are covered per Plan provisions.

Plan Provision	HDHP Option: What You Pay		HDHP Base Option: What You Pay	
	Network	Non-Network	Network	Non-Network
Maternity Care <i>For births without complications, the Plan provides a minimum 48-hour <u>hospital</u> stay following childbirth (96-hours minimum stay following a cesarean section delivery)</i> <i><u>Hospital</u> or birth center stays beyond 48 hours (or 96 hours) must be medically necessary</i>	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Allergy Testing and Treatment or other injections (such as hormone injections)				
Office Visit (with <u>physician</u>), Shot and Antigen; Allergy Testing	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Shot or Antigen Only, No Other Service	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Hospital Expenses				
<u>Hospital</u> Room and Board <i>Semiprivate room rate</i>	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Inpatient Expenses	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient Expenses	20% after deductible	40% after deductible	20% after deductible	40% after deductible
<u>Pre-Admission Testing</u>	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Organ and Soft Tissue Transplants	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Travel Expenses for: <u>Solid organ</u> and bone marrow transplants and other specialized care that cannot be provided within the patient's local geographic area	You pay travel and lodging expenses (with some limits) that exceed a combined maximum of \$10,000 per episode of care. ⁶ Preapproval through the <u>Claims Administrator</u> is required.  "Blue Distinction Centers," page B-28		You pay travel and lodging expenses (with some limits) that exceed a combined maximum of \$10,000 per episode of care. ⁶ Preapproval through the <u>Claims Administrator</u> is required.  "Blue Distinction Centers," page B-28	
Travel and lodging expenses for: Complex cardiac, orthopedic and bariatric surgeries from a <u>Blue Distinction Center</u>	You pay travel and lodging expenses (with some limits) that exceed a combined maximum of \$10,000 per episode of care. ⁶ Preapproval through the <u>Claims Administrator</u> is required. Bariatric surgery is covered only if at a <u>Blue Distinction Center</u> .  "Blue Distinction Centers," page B-28		You pay travel and lodging expenses (with some limits) that exceed a combined maximum of \$10,000 per episode of care. ⁶ Preapproval through the <u>Claims Administrator</u> is required. Bariatric surgery is covered only if at a <u>Blue Distinction Center</u> .  "Blue Distinction Centers," page B-28	

(continued)

⁶ For transplant-related travel expenses, an illness begins at the point of authorization for evaluation for a transplant or for specialized care and ends (1) 180 days from the date of the transplant or specialized care; or (2) upon the date you are discharged from the hospital for the admission related to the transplant or specialized care, whichever is later.

Plan Provision	HDHP Option: What You Pay		HDHP Base Option: What You Pay	
	Network	Non-Network	Network	Non-Network
Emergency Services				
Emergency Room Expenses	20% after deductible	20% after deductible	20% after deductible	20% after deductible
<u>Urgent Care</u>	20% after deductible	40% after deductible	20% after deductible	40% after deductible
<u>Non-Emergency Use of Emergency Room</u> and All Related Expenses	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Mental Health & Substance Use Disorder Treatment				
<u>Inpatient or Outpatient Mental Health/ Substance Use Disorder Treatment</u>	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Dental-Related Expenses				
Dental Injuries and Diseases	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Temporomandibular Joint Dysfunction (TMJ)	Only the diagnosis of TMJ is covered. Appliances, restoration and procedures for treatment of TMJ are not covered.		Only the diagnosis of TMJ is covered. Appliances, restoration and procedures for treatment of TMJ are not covered.	
Nursing Services				
Home Health Care <i>Up to 120 visits per calendar year</i>	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Hospice Inpatient Care	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Hospice Outpatient Care	20% after deductible	40% after deductible	20% after deductible	40% after deductible
<u>Skilled Nursing Facility/Convalescent Nursing Home</u> <i>Semiprivate room rate. Up to 60 days per calendar year. Custodial care is not covered.</i>	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Prescription Drugs				
Retail and Mail Order/ Maintenance Choice	See the chart in “Prescription Drug Coverage” for details.  “Prescription Drug Coverage,” page B-39		See the chart in “Prescription Drug Coverage” for details.  “Prescription Drug Coverage,” page B-39	

(continued)

Plan Provision	HDHP Option: What You Pay		HDHP Base Option: What You Pay	
	Network	Non-Network	Network	Non-Network
Other				
Air and Ground Ambulance (emergency use only) ⁷	20% after deductible	20% after deductible	20% after deductible	20% after deductible
<u>Spinal Manipulation</u> <i>Must be performed by chiropractor, physical therapist, osteopath; maximum of 20 visits per calendar year</i>	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Diagnostic Lab and X-rays <i>Includes complex imaging⁸</i>	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Durable Medical Equipment and Supplies	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Hearing Aids Maximum: 1 aid per ear every 36 months (includes fitting)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Voluntary Sterilization ⁹ <i>Reversal of sterilization is not covered</i>	20% after deductible	40% after deductible	20% after deductible	40% after deductible
<u>Fertility Treatment</u> ¹⁰ , including In-Vitro Fertilization and Artificial Insemination	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Acupuncture Therapy <i>Covered if <u>medically necessary</u> and in lieu of <u>anesthesia</u></i>	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Short-term Therapy ¹¹ such as: <u>Occupational Therapy</u> <u>Physical Therapy</u> <i>Combined maximum of 60 visits per calendar year¹²</i>	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Services by the Houston or The Well Onsite Medical Clinics	100% after deductible	N/A	100% after deductible	N/A

⁷ Per No Surprise Act (NSA), air ambulance services from a non-network provider will be covered at network reimbursement level, which will be based on the Qualified Payment Amount in compliance with NSA as determined by the Claims Administrator. Ground ambulance services are excluded from NSA provisions.

⁸ Some services require pre-authorization.

⁹ Tubal ligations are covered as preventive medical care.

¹⁰ Fertility lifetime maximum is \$20,000 for medical services and \$10,000 for prescription drugs and injections.



¹¹ Is not considered spinal manipulation.

¹² Excludes autism spectrum disorder diagnosis.

Medical Options

Provided you meet the eligibility requirements, you may be eligible for the following medical options:

 “Who Is Eligible,” page B-5

- The High Deductible Health Plan (HDHP) option; and
 “About the High Deductible Health Plan (HDHP) & HDHP Base Options,” page B-18
- The High Deductible Health Plan Base (HDHP Base) option.
 “About the High Deductible Health Plan (HDHP) & HDHP Base Options,” page B-18


The medical options cover a wide range of medically necessary services and supplies, including medical, mental health/substance use disorder, health improvement programs and prescription drug coverage. **To encourage preventive medical care such as routine physicals, the annual deductible is waived on all covered preventive medical care expenses in all medical options.**

You can save both time and money when you choose to receive your care from network providers. This is because network providers have contracted with the Claims Administrator to provide their services at negotiated rates and to file the medical claims for those services. This means that the dollar amount you pay for your share of the covered expense is lower when you use a network provider.


Generally, the provider (physician, hospital, clinic, etc.) files medical claims with the Claims Administrator on your behalf. If they don’t, you’ll need to pay the entire cost of the service at the time it’s received and then file a claim with the Claims Administrator for reimbursement.

 “How to File a Claim,” page B-47

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- ✓ The benefits provided by the medical options are briefly described in this section and in the “Employee Medical Benefit Highlights” section.

 “Employee Medical Benefit Highlights,” page B-11

Additional information on expenses covered and not covered by the Plan is included beginning on page B-29. Prescription drug benefits are described beginning on page B-39.

 “Covered Expenses,” page B-29; “Non-Covered Expenses,” page B-35; “Prescription Drug Coverage,” page B-39

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- ✓ **The Benefits Committee has authority to make temporary changes in Plan provisions as appropriate, at the Benefits Committee’s discretion, to respond to a natural or man-made emergency or disaster so participants can obtain covered services and benefits. In any such instance, the Benefits Committee shall adopt administrative procedures specifying the changes and the duration of such changes.**
-

✓ See “About Network Providers” for information on finding a network provider, accessing network care, covering eligible dependent children who live away from home, and transition of care and continuity of care benefits for new Plan participants.

 “About Network Providers,” page B-21

About the High Deductible Health Plan (HDHP) & HDHP Base Options

The HDHP and HDHP Base options are network-based medical options that give you a choice when accessing your medical care. You can go to:

- Any network provider — Any health care provider, hospital or facility that the Claims Administrator has designated as part of its provider network for the service or supply being provided — and receive the network reimbursement level; or
- Any non-network provider — Any health care provider, hospital or facility that the Claims Administrator has not designated as part of its provider network for the service or supply being provided — and not receive the network reimbursement level.

These options have an annual deductible that must be met before the options begin to pay for services, including prescription drugs (the deductible is waived on preventive medical care). The HDHP option also waives the annual deductible on certain eligible generic preventive prescription drugs and insulin.

 “Employee Medical Benefit Highlights,” page B-11; “Annual Deductible,” page B-23

Network Providers

When you receive services from a network provider, the HDHP and HDHP Base options generally pay 80% of the negotiated rate for most covered expenses after the annual deductible is met, and you pay the remaining portion of the charges (the coinsurance).

 “Annual Deductible,” page B-23

Once you meet the annual out-of-pocket maximum, the HDHP and HDHP Base options generally pay 100% of the negotiated rate for most covered expenses (including prescription drug benefits) for the rest of the plan year.

 “Annual Out-of-Pocket Maximum,” page B-24

Non-Network Providers

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- ✓ If you receive services from a non-network provider when you can’t control who is involved in your care (such as an emergency), you are protected from any “balance billing.” See “Using Network Providers” for further information.

 “Using Network Providers,” page B-21

If you receive non-emergency care services from a non-network provider or non-network facility, the HDHP and HDHP Base options generally pay 60% of most covered expenses, subject to reasonable and customary limits, after the non-network annual deductible is met. You pay the remaining coinsurance and any costs over reasonable and customary limits.

 “Employee Medical Benefit Highlights,” page B-11

Once you meet the non-network annual out-of-pocket maximum, the HDHP and HDHP Base options generally pay 100% for most covered expenses (including prescription drug benefits), subject to reasonable and customary limits, for the rest of the plan year.

✓ See “ParPlan (PAR) Providers” for information applicable to non-network providers.

📄 “ParPlan (PAR) Providers,” page B-26

The HDHP and HDHP Base Options and Health Savings Accounts (HSAs)

An HSA is a tax-advantaged savings account that can help you pre-fund and pay for your current medical expenses with tax-free dollars.

To be eligible for an HSA, you:

- Must be covered under a high-deductible health plan (HDHP) as defined by the IRS. The HDHP and HDHP Base options under this Plan meet this criterion;
- Cannot be covered by any other non-HDHP medical coverage¹ (e.g., be covered as a dependent under a spouse’s non-HDHP plan or receive coverage under a Tricare Plan);
- Cannot be covered by any part of Medicare, including Part A; and
- Cannot be claimed as a dependent on another person’s federal income tax return. **Note:** Your child can be covered as an eligible dependent under the HDHP or HDHP Base option. However, if he or she does not qualify

as a dependent on your federal income tax return or if you do not provide at least 50% of his or her support, you cannot use your HSA funds for the child’s qualified medical expenses.

HSAs are designed to help you pay current and future medical expenses. Here’s how the HSA works:

- When you elect either the HDHP or HDHP Base option with an HSA, you are electing to set up a Bank of America (BoFA) HSA account in your name.
- You may contribute to your HSA on a before-tax basis through payroll deductions. You can elect and change the payroll deduction amount at any time prior to Nov. 2 of the calendar year and the change will be effective the following month. Your election will continue from year to year. You can also make after-tax contributions directly with BoFA subject to annual IRS contribution limits.
- If you elect the HDHP option, the Company may make an annual contribution (maximum of \$600 for “employee only” coverage and \$1,000 for other coverage levels in 2025) to your BoFA HSA on your behalf.
- If your coverage effective date is Nov. 2 or after, you will not be eligible for a Company HSA contribution.
- If you are on an unpaid leave of absence when the Company HSA contribution is made, the Company HSA contribution will be deferred until your leave of absence ends. The contribution will be paid according to Plan eligibility requirements and the Plan provisions listed in the chart below. For assistance with requesting your Company HSA contribution, please contact the Benefits Center.

📄 “Contacts,” page A-1

- The Company HSA contribution is:

Date HDHP Coverage Begins	Coverage Level	Percent of Annual Company Contribution	Company Contribution
Jan. 1 through June 30	<ul style="list-style-type: none"> • You only • Other coverage levels 	<ul style="list-style-type: none"> • 100% • 100% 	<ul style="list-style-type: none"> • \$600 • \$1,000
July 1 through Nov. 1	<ul style="list-style-type: none"> • You only • Other coverage levels 	<ul style="list-style-type: none"> • 50% • 50% 	<ul style="list-style-type: none"> • \$300 • \$500
Nov. 2 through Dec. 31	<ul style="list-style-type: none"> • You only • Other coverage levels 	<ul style="list-style-type: none"> • 0% • 0% 	<ul style="list-style-type: none"> • \$0 • \$0
You are eligible to receive the Company contribution once in a calendar year			

¹ If you receive benefits from the Veterans Administration or Indian Health Services, other than dental, vision or preventive services, you must discontinue contributions to your HSA for a period of three calendar months following the calendar month in which services were received.

- The annual statutory maximum contribution amount that may be contributed to an HSA is set by the IRS, varies from year to year and is based upon your level of coverage (coverage for yourself only, or coverage for you and your family).
 - If you're over age 55 and aren't enrolled in Medicare, you can make additional catch-up contributions to your HSA each year. For additional information, see Publication 969 at www.irs.gov.
 - If your spouse also contributes to an HSA, your maximum amount you can contribute to an HSA will be reduced.
- You can also make after-tax contributions to an HSA which are deductible on your federal income tax return, and you can contribute after-tax funds at any time prior to the due date of your income tax return for that tax year.
- The money you put into an HSA may earn interest or may have investment features that accumulate on a tax-free basis.
- Any money you take out of your HSA to pay eligible medical expenses is not subject to federal income taxes.
- You can take money out of your HSA for reasons other than eligible medical expenses. However, such withdrawals are subject to regular income tax plus a penalty tax.
- There's no "use or lose" rule in an HSA. Any money remaining in your HSA at the end of the year can be rolled over for use in future years.
- Your HSA belongs to you at all times — it's not dependent upon your employment at ConocoPhillips.
- If you stop participating in an HDHP, you can use the funds remaining in your HSA for qualified medical expenses, but you cannot make any new contributions to the HSA.

The BofA HSA program is voluntary. You're the account holder, and you're responsible for reporting HSA contributions and distributions (whether by you or on your behalf) to the IRS. **You should consult your tax or financial advisor to make sure you're eligible for an HSA, to see if an HSA and any additional catch-up contributions would be advantageous to you, to know the impact on your contributions if your spouse contributes to an HSA, to see if you should contribute any after-tax funds in addition to payroll deductions or while on a leave of absence and to ensure that you understand all of the tax implications.** To learn more about HSAs, see Publication 969 at www.irs.gov.

✓ If you enroll in either the HDHP or HDHP Base option with an HSA, your BofA HSA is set up automatically on your behalf. If you are not eligible for an HSA, but still want either HDHP or HDHP Base coverage, you should enroll in the appropriate HDHP without an HSA.

✓ If you enroll in the HDHP Base option, you are eligible for an HSA, but you are not eligible for any Company contributions.

It's the intention of ConocoPhillips to comply with the Department of Labor guidance set forth in Field Assistance Bulletins No. 2004-1 and 2006-02, which specify that a Health Savings Account (HSA) isn't an ERISA plan if certain requirements are satisfied. The BofA HSA described in this SPD isn't an arrangement that's established and maintained by ConocoPhillips. Rather, the HSA is established and maintained by the HSA trustee/custodian. However, for administrative convenience, a description of the HSA and information on the BofA HSA are provided in these materials.


How the Employee Medical Plan Works

About Network Providers

-
- ✓ The Plan allows you to choose the primary care physician or pediatrician you want from the network, and you can see an OB-GYN physician without needing a referral.
-

For all medical options, benefits are paid based on whether care is received from network or non-network providers. Plan provisions differ, depending on the option in which you're enrolled.

To Find a Network Provider

- Ask your provider if he or she is a Blue Choice PPO network provider;
 - Use online resources:
 - Blue Cross and Blue Shield of Texas Provider Finder® directory at www.bcbstx.com; or
 - hr.conocophillips.com; or
 - Call the Claims Administrator and get the information over the phone or ask for a directory to be sent to you.
-  "Contacts," page A-1

You can obtain a provider list for the network used by the Claims Administrator free of charge at any time by making a request to the applicable Claims Administrator. The Claims Administrator will respond to your inquiry about the network status of a provider or facility within one business day. The Claims Administrator provider directory will be updated no less than every 90 days and in general, if you received services from a provider listed incorrectly as network, you will only be subject to network reimbursement level. It's your responsibility to remain aware of your provider's network status.

Using Network Providers

For all medical options, benefits are determined by whether the treatment or service is received from network providers or from non-network providers.

The Claims Administrator's network physicians include primary care physicians, gynecologists, radiologists, anesthesiologists, pathologists, chiropractors, podiatrists, mental health and substance use disorder

providers and other specialists. The network also includes hospitals, medical laboratories, physical therapists, radiology centers and rehabilitation services.

It's generally your responsibility to ensure that you use network providers if you want to receive the network reimbursement level. Be sure to specify that all treatment be given by network providers and check with the provider to ensure they're part of the network before receiving services.

Effective Jan. 1, 2022, the No Surprises Act (NSA)¹ helps protect you from balance billing when you receive emergency care or are treated by a non-network provider at a network facility. This means in most cases you will not be responsible for more than if you received network services.

Generally, you can expect:

- Coverage for emergency care without requiring you to get approval for services in advance (pre-authorization).
- Coverage for emergency care by non-network providers.
- Coverage for non-emergency services provided by non-network providers at a network facility.²
- The amount you owe the provider or facility to be based on network reimbursement level and shown in your explanation of benefits.
- Amounts you pay for emergency care or non-network services to be counted toward your network annual deductible and annual out-of-pocket maximum.

If you think you've been wrongly billed, please contact the Claims Administrator.

¹ The NSA is part of the Consolidated Appropriations Act of 2021, which provides federal protections against surprise billing and limits non-network cost sharing under many of the circumstances in which surprise bills arise most frequently.

² The NSA helps protect you from balance billing when you receive non-emergency care from non-network providers working at network facilities unless the non-network provider provides notice to you and you provide consent in advance of the service. This advance notice and consent exception to the NSA protections does not apply to ancillary providers, which include anesthesiology or emergency care.


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- ✓ It is the intention of ConocoPhillips to comply with the Consolidated Appropriations Act, inclusive of the No Surprises Act and other provisions, using good faith and reasonable interpretation of the statute.
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If a Network Provider Is Not Available (Network Deficiency)

NOTE: See page B-42 for network deficiency provisions on prescription drugs.

A network deficiency is a situation in which the Claims Administrator doesn't have network providers for certain specialties within its established network of physicians and hospitals for a certain area. A network deficiency doesn't exist if there's an appropriate network provider within a reasonable driving distance (50 miles) of your home address.¹

Prior approval from the Claims Administrator is required before any services by a non-network provider can be deemed to be covered by network deficiency provisions and you may be required to take further action to obtain that approval. The Claims Administrator will not approve a network deficiency if there is a network provider closer to your home than the non-network provider for which you are requesting an exception. **Networks are applicable to providers in the United States only.**

If a <u>network provider</u> IS available in your network area (meaning there's no <u>network deficiency</u>)	If you choose to use a <u>non-network provider</u> , your claim will be paid at the non-network reimbursement level.
If a <u>network provider</u> is NOT available within 50 miles of your home address (network area) ¹ and you want to use a <u>non-network provider</u>	<p>You must request approval from the <u>Claims Administrator</u> at least 10 calendar days in advance of any service or treatment. If approved, it is your responsibility to request a case-specific rate negotiation with the <u>Claims Administrator</u>. This allows the <u>Claims Administrator</u> to negotiate rates with the provider. If both parties agree, your claim will be paid according to the <u>negotiated rate</u>, subject to cost sharing. If an agreement is not reached, your claim will be processed at the network reimbursement level and if you are balance billed, contact the <u>Claims Administrator</u> to have your claim adjusted so your cost sharing does not exceed the network reimbursement level. The <u>Claims Administrator</u> will work with you to find the closest appropriate provider for a <u>network deficiency</u> or whether the Travel Assistance benefit is available for specialized care situations that may require additional travel.</p> <p> "Medical," page B-14</p> <p>After receiving authorization from the <u>Claims Administrator</u> to use a <u>non-network provider</u> for a <u>network deficiency</u>, the authorization for the network reimbursement level is effective per the timeframe stated on the approval letter from the <u>Claims Administrator</u>.</p> <p>If additional care is required, you must contact the <u>Claims Administrator</u> prior to the expiration of the <u>network deficiency</u> to request an extension.</p> <p>Claims will be paid at the non-network reimbursement level if:</p> <ul style="list-style-type: none"> • A <u>non-network provider</u> is used and you didn't receive a <u>network deficiency</u> authorization from the <u>Claims Administrator</u>; or • The <u>Claims Administrator</u> did grant authorization, but the authorization has expired.
If you or a covered dependent live outside the network area	<p>You'll need to travel to the nearest network area for care and use a <u>network provider</u> in order for your claim to be paid at the network reimbursement level. Otherwise, the claim will be paid at the non-network reimbursement level.</p> <p>A <u>network deficiency</u> (based on the employee's home address on record at ConocoPhillips) will not be granted unless the network area doesn't have the <u>network provider</u> you need.</p>

¹ For participants living in Alaska, a network deficiency will be deemed to exist any time at least two network providers are not available within a radius of 30 miles from a participant's home address. Once the Claims Administrator has approved a network deficiency, the approval shall remain effective, with regard to the covered person, for a period of six months from the approval date.

Regardless of the above, your services may be covered at the network reimbursement level if the Claims Administrator determines that the services you received meet the criteria for emergency care.

Transition of Care and Continuity of Care

If you are actively receiving services for specified medical and behavioral conditions, as defined by the Claims Administrator, with a non-network provider when your coverage becomes effective, the Claims Administrator may determine it is appropriate to allow you a transitional period so that your care can continue with the non-network provider until treatment is completed or care can be safely transferred to a network provider.

If you are actively receiving services for specified medical and behavioral conditions, as defined by the Claims Administrator, with a non-network provider due to a change in the Claims Administrator's network, you may be able to request to continue care with the non-network provider with the Claims Administrator.

If the Claims Administrator approves transition or continuity of care, claims with the approved non-network provider will be paid as network and possibly subject to reasonable and customary limitations, for a defined period of time, as determined by the Claims Administrator and in compliance with the No Surprises Act. **In order to ensure you receive the highest level of benefits, contact the Claims Administrator and obtain approval prior to continuing any treatment with your current non-network provider.**

 “Contacts,” page A-1

Some Basic Terms

Annual Deductible



The annual deductible is the initial amount you pay for covered medical services you receive each calendar year before the Plan begins paying benefits. Deductibles vary depending on your medical option. See page B-12 for the annual deductible amounts.

- **If you have You Only coverage:** You must meet the annual individual deductible before most benefit payments begin.
- **For other coverage levels:** The annual individual deductible doesn't apply. Instead, the annual family deductible must be met before most benefit payments begin for any covered family member. The annual family deductible can be met by one covered individual or any combination of covered family members.
- All eligible expenses count toward the deductible, regardless of whether they were incurred with network providers or non-network providers.
- When an employee changes to a different coverage level during the calendar year, all expenses applied to the deductible will also be applied to the new coverage-level deductible.

✓ References to the “You Only” coverage level are for employee-only, spouse-only or child-only enrollments.

✓ References to coverage levels other than “You Only” include You + Child, You + Spouse, You + Children and You + Family (You + Spouse + Children).

The following expenses paid by you do **not** apply to the annual deductible:

- Expenses not covered by the Plan;
- Expenses in excess of reasonable and customary limits (not applicable if a non-network charge is subject to the No Surprises Act);
- Prescription drug expenses **do** apply to the annual deductible, except for the following:
 - Amounts you pay for the Retail Refill Allowance penalty (when you exceed the retail fill allowance for maintenance medications);
 - Amounts you pay for the Brand/Generic Difference (the difference in cost between the brand-name drug or non-preferred brand-name drug and the available equivalent generic drug), however, the cost of the equivalent generic drug will apply to your annual deductible;
 “Prescription Drug Coverage,” page B-39
 - Amounts you pay for failing to adhere to Prior Authorization, Preferred Drug Therapy, Specialty Prescription Drugs and Quantity/Dose Limits;
- Coinsurance amounts that are paid by a manufacturer coupon or rebate for Specialty Prescription Drugs;
- Pre-authorization penalties; and
 “Pre-Authorization Penalties,” page B-27
- Preventive medical care expenses paid by the Plan.

If You Change Medical Options During the Calendar Year

If a change in status results in a different option, expenses incurred year-to-date under your **original** option will be considered toward satisfying any applicable annual deductibles and annual out-of-pocket maximums under your **new** option if:

- The expenses would have counted toward those limits under the new option; and
- The expenses were incurred in the calendar year in which the change in status occurred.

Note: When changing to an option with a lower deductible, any expenses in excess of the new lower annual deductible will not be applied toward the new option's annual out-of-pocket maximum.

Coinsurance

Coinsurance is the percentage of covered expenses you pay for medical services once you satisfy any required annual deductibles. For example, if you meet the network annual deductible for covered expenses, your coinsurance percentage is generally 20% — with the Plan paying 80% — of most covered expenses for you and your covered family members.

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the maximum amount you pay each calendar year for covered medical services before your medical option begins paying 100% of covered expenses. The annual out-of-pocket maximum varies, depending on your medical option. See page B-12 for the annual out-of-pocket maximum amounts.



- **If you have You Only coverage:**

- The individual annual out-of-pocket maximum must be met before the Plan begins paying 100% of most covered expenses.
- All eligible expenses count toward the annual out-of-pocket maximum, regardless of whether they were incurred with network providers or non-network providers.

- **For other coverage levels:**

- An **individual** network annual out-of-pocket maximum may apply even if the family annual out-of-pocket maximum has not yet been met. Once an individual has met the individual network annual out-of-pocket maximum, the Plan begins paying 100% of eligible network claims for that individual for the rest of the calendar year regardless of whether the family annual out-of-pocket maximum has been met.
- Once the **family** annual out-of-pocket maximum has been met, the Plan begins paying 100% of most covered expenses for all covered individuals. The family annual out-of-pocket maximum can be met by any combination of one or more covered family members.
- All eligible expenses count toward the annual out-of-pocket maximum, regardless of whether they were incurred with network providers or non-network providers. Network expenses, as determined by the Claims Administrator, will count toward the **individual** annual out-of-pocket maximum.
- When an employee changes to a different coverage level during the calendar year, all expenses applied to the annual out-of-pocket maximum will also be applied to the new coverage-level annual out-of-pocket maximum.

The following expenses paid by you do **not** apply to the annual out-of-pocket maximum:

- Expenses not covered by the Plan;
- Expenses in excess of reasonable and customary limits (not applicable if a non-network charge is subject to the No Surprises Act);
- Prescription drug expenses **do** apply to the annual out-of-pocket maximum, except for the following:
 - Amounts you pay for the Retail Refill Allowance penalty (when you exceed the retail fill allowance for maintenance medications);
 - Amounts you pay for the Brand/Generic Difference (the difference in cost between the brand-name drug or non-preferred brand-name drug and the available equivalent generic drug), however, the cost of the equivalent generic drug will apply to your annual out-of-pocket maximum;
 -  “Prescription Drug Coverage,” page B-39
 - Amounts you pay for failing to adhere to Prior Authorization, Preferred Drug Therapy, Specialty Prescription Drugs and Quantity/Dose Limits;
- Coinsurance amounts that are paid by a manufacturer coupon or rebate for Specialty Prescription Drugs;
- Pre-authorization penalties; and
 -  “Pre-Authorization Penalties,” page B-27
- Preventive medical care expenses paid by the Plan.

Lifetime Maximum Benefit

Fertility treatment consisting of in-vitro fertilization and artificial insemination is limited to a \$30,000 lifetime maximum benefit (\$20,000 for medical services and \$10,000 for prescription drugs and injections).

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- ✓ For participants who change coverage from the Expatriate Medical and Dental Plan to the Employee Medical Plan, claims paid under the Expatriate Medical and Dental Plan will be applied to the annual and lifetime maximums in the Employee Medical Plan.
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Important Plan Features

ParPlan (PAR) Providers

The Claims Administrator has ParPlan, which is contractual arrangements with non-network providers (physicians, hospitals and other ancillary professionals) to bill an allowable amount below their normal charge without billing you for the balance and to file claims for you. You save money with PAR. Contact the Claims Administrator or ask a provider if they are part of PAR.

 *"Contacts," page A-1*

MDLive

MDLive is a service provided by your medical Claims Administrator that provides medical consultation via telephone for acute health issues such as cold/flu type symptoms, minor eye, ear and respiratory infections or a need to talk with a psychologist or psychiatrist. MDLive is available 24 hours a day, seven days a week. MDLive physicians can issue prescription drugs for a variety of acute care items and can phone the prescription into the pharmacy you choose for easy pickup. Consultations through MDLive cost around \$48, a significant savings versus the cost of a typical physician visit, and all payments to MDLive count toward meeting your annual deductible and annual out-of-pocket maximum.

 *"Contacts," page A-1*

Blue Access for Members (BAM)

Blue Access for Members is the medical Claims Administrator's member and consumer self-service website that provides online benefits and health-related information. Through BAM, you can register for a secure, personalized view of your medical benefits, review the status of your claims, view Explanation of Benefits (EOB) statements, request ID cards, look up providers and access health information. To register, go to www.bcbstx.com.

2nd MD

If you are faced with a serious medical condition and question the reasonableness of a treatment recommendation, question the necessity of a recommended procedure or do not respond to medical treatment after a reasonable amount of time, you may use the 2nd MD program. Contact the medical Claims Administrator or go to hr.conocophillips.com for additional details.

 *"Contacts," page A-1*

Health Advocacy Solutions (HAS)

When you contact the medical Claims Administrator, you reach a health advocate. These specialists, including registered nurses, social workers and health and behavioral advocates, work together to coordinate complex care needs, help schedule your appointments, talk about claims issues, and even manage simple issues such as replacing your insurance ID cards.

Well-Being Management

Well-Being Management is a service provided by your medical Claims Administrator that provides consultation on lifestyle assistance (tobacco usage and weight loss reduction), nurse assistance, case management and condition management.

 *"Contacts," page A-1*

Blue365

Blue365 is a way to save you money by providing access to and a discount from a variety of health and wellness products and services such as eye care, hearing services, dental care, fitness products, etc. There are no claims to file and no referrals or pre-authorization required.

 *"Contacts," page A-1*

Pre-Authorization

Pre-authorization is an up-front review of the need for (and length of) a stay in certain kinds of facilities and receipt of certain services within the United States. If you're using a network provider, your physician will arrange pre-authorization for you. Radiology pre-authorization is an up-front review of the need for a detailed diagnostic image (such as MRI, CT, Pet, etc.) and other radiology services. These services may not be covered unless your physician requested approval from the Claims Administrator in advance.

You must call the Claims Administrator to be pre-authorized before you or a covered family member checks into a non-network hospital or if your non-network hospital stay is extended beyond the number of days pre-authorized.

 "Contacts," page A-1

- **Inpatient admissions** — Call the Claims Administrator at least 14 days in advance of your hospital admission to pre-authorize your non-network hospital stay. A pre-authorization is valid for 60 days as long as you remain covered by the Plan.
- **If you're hospitalized due to a medical emergency** — Your hospital admission must be pre-authorized within 48 hours of admission (72 hours, if the admission is on Friday or Saturday). You, your physician or the hospital can request the pre-authorization by calling the Claims Administrator at the number shown on your ID card. If it's not possible to meet the 48- or 72-hour timeframe, the admission must be authorized as soon as it's reasonably possible.

Pre-authorization is **not** required for:

- Services received in a foreign country; or
- Hospital admissions for childbirth, if the hospital stay for the birth is expected to be less than or equal to 48 hours for a vaginal delivery or less than or equal to 96 hours for a cesarean section. However, you must pre-authorize your inpatient hospital stay for the mother and/or newborn child if the stay will be longer than the 48- or 96-hour timeframes.

Pre-Authorization Penalties

If you fail to pre-authorize non-network hospital stays:

- Hospital room and board benefits will be reduced by \$200; and
- Benefits will **NOT** be paid for any care that's not medically necessary as determined by the Claims Administrator.

Pre-authorization requirements and penalties also apply to a skilled nursing facility, hospice care, home health care and rehabilitation facilities.

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- ✓ While network providers generally obtain pre-authorization of care for you, **you're** responsible for making sure the pre-authorization is obtained for non-network services. Penalties don't apply to network hospital stays as long as the pre-authorization was obtained.
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Predetermination of Benefits

Predetermination of benefits is your opportunity to review if a service is medically necessary and if it will be covered by the Plan. Obtaining a predetermination can help ensure the appropriateness of the proposed treatment and may be able to reveal other options. You decide whether you want to obtain a predetermination of benefits — there is no penalty if a predetermination isn't obtained. However, if you choose not to obtain a predetermination prior to receiving services, you may be responsible for the cost of any services determined not to be medically necessary.

To see if a proposed treatment is covered by the Plan, you or your provider will need to submit a Predetermination Form that can be obtained from the Claims Administrator.

 "Contacts," page A-1

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- ✓ The Plan doesn't pay benefits for services that are determined not to be medically necessary. Obtaining a predetermination of benefits can help you avoid incurring such an expense.
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Utilization Review and Patient Management

The patient management program monitors and evaluates the appropriateness of medical care resources and prescriptions utilized by Plan participants. The Claims Administrator uses nationally recognized guidelines and resources to guide the review processes. On the basis of information collected from providers and participants, the Claims Administrator applies industry-accepted guidelines and clinical policies developed by the Claims Administrator. Contact the Claims Administrator if you would like more information about this program.

 *"Contacts," page A-1*

Blue Distinction Centers (BDC)

The Blue Distinction Centers are facilities that have demonstrated high volumes and produced clear clinical results in their area of specialty. Contact the Claims Administrator for further information. In some cases, travel to a BDC facility for certain covered procedures may be reimbursed, subject to IRS guidelines. Please contact the Claims Administrator for details.

You or your provider must call the Claims Administrator to request approval before travel expenses are incurred.

Preapproval is required.

 *"Contacts," page A-1*

The Claims Administrator makes the determination as to whether the care for which you're requesting authorization meets the criteria to be eligible for travel and lodging reimbursement. If the Claims Administrator determines that the care for which you're requesting authorization doesn't meet the criteria to be eligible for the travel and lodging reimbursement, your request for any travel and lodging expenses will be denied.

Traveling Outside the United States

If you require medical services while traveling outside the United States on pleasure or business, call the Claims Administrator service center that assists travelers outside the United States to find a doctor or hospital. If you receive inpatient care at a hospital arranged by the Claims Administrator, the hospital should submit the claim on your behalf but you will need to pay up front for all other services and costs you normally would incur, according to the rules of your medical option. If you need inpatient care, you will also need to call your regular medical Claims Administrator (phone number on back of your ID card) for precertification or preauthorization. For the services you pay for, you will need to submit the international claim form to the Claims Administrator for reimbursement.

 *"Contacts," page A-1*

Emergency services received anywhere in the world are always reimbursed at the network reimbursement level. Non-emergency services will be considered non-network.

Covered Expenses

If not otherwise documented in this SPD, the medical Claims Administrator's Standards (as explained in Medical Policies), the guidelines of any agent selected by the Claims Administrator to assist in a determination of medically necessary, and/or accepted medical practice will govern the benefits offered and the criteria that must be met in order for benefits to be covered under the Plan. A link to the Medical Policies is on hr.conocophillips.com.

The Plan covers a broad range of medical services and supplies that are **medically necessary** as determined by the Claims Administrator, subject to each medical option's annual deductible, coinsurance, exclusions and limitations — including reasonable and customary limitations.

Note: While you and your physician decide on the services and supplies to be provided to you, it's possible that the Claims Administrator could find certain services or supplies to be unnecessary or not covered by the Plan. If you're not sure a service or supply is covered by the Plan, it's always a good idea to contact the Claims Administrator for coverage information **before** incurring expenses.

 "Contacts," page A-1

✓ The Claims Administrators for the medical options are authorized from time to time to include special coverage programs without charge to the Plan and/or the participants to improve safety, health and cost trends.

Medical services and supplies covered by the Plan include:

Durable Medical Equipment

- Durable medical equipment, providing the equipment meets **all** of the following conditions:
 - It's for repeated use and isn't a consumable or disposable item;
 - It's used primarily for a medical purpose;
 - It's appropriate for use in the home; and
 - It's prescribed by a physician.

Examples of durable medical equipment include:

- Appliances that replace a lost body organ or part or help an impaired one to work;
- Orthotic devices, such as arm, leg, neck and back braces. (**Note:** Foot orthotic devices aren't eligible under the Plan. Contact the Claims Administrator for medical conditions and devices that may be covered);
- Hospital-type beds;
- Equipment needed to increase mobility, such as a wheelchair;
- Respirators or other equipment for the use of oxygen; or
- Monitoring devices.

The Claims Administrator should be contacted prior to rental or purchase of durable medical equipment. The Claims Administrator decides whether to cover the purchase or rental of the equipment. Modifications to the home aren't covered.

Maintenance and repairs needed due to misuse or abuse are not covered. Coverage is limited to one item of equipment, for the same or similar purpose, and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Foot Care

- Foot care for podiatric surgery (e.g., surgery for bunions and hammertoes). In addition, hygienic foot care may be eligible for coverage in patients who suffer from systemic diseases and such treatment requires the care of a qualified provider of foot service. These diseases include peripheral vascular disease, metabolic or neurological disease (e.g., trimming of toenails or calluses for individuals who have diabetes, arteriosclerosis and Buerger's Disease).

Expenses for foot orthotic devices are NOT covered by the Plan. Contact the Claims Administrator for medical conditions and devices that may be covered.

Ears

- One hearing aid per ear every 36 months.
- One cochlear implant, which includes an external speech processor and controller, per impaired ear is covered. Coverage also includes related treatments such as habilitation and rehabilitation services, fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids. Implant components may be replaced as medically necessary or audiologically necessary.

Hospices, Hospitals, Home Care and Institutions

- Home health care (includes skilled nursing care, home health aide services and medical social services when provided in conjunction with skilled nursing care, and skilled behavioral health care services) that is ordered by a physician as part of a home health care plan when you are transitioning from a hospital or other inpatient facility and the services are in lieu of being a continued inpatient or you are homebound. The skilled nursing care and home health aide services require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. The medical social services must be provided by a qualified social worker and the behavioral health care services must be provided by a qualified behavioral health provider. All home health care must meet the following criteria:
 - The service must be provided by intermittent or hourly visits (a waiver may be made for services within 10 days of discharge from a hospital or skilled nursing facility);
 - Skilled nursing care visits are limited to a maximum of 3 visits per day. Visits are covered up to 120 maximum per calendar year;
 - Services are not provided by a authorized or licensed social worker, except for medical social services;
 - Services are provided by someone other than a person who usually lives with you, or who is a member of your or your spouse's or your domestic partner's family;
 - Services are not for transportation or custodial care;
 - Services cannot be provided to a minor or dependent adult when a family member or caregiver is not present; and

- Services must be reasonable and necessary for the treatment of the illness or injury — that is, the services must be consistent with the unique nature and severity of your illness or injury, your particular medical needs and accepted standards of medical and nursing practice, without regard to whether the illness or injury is acute, chronic, terminal or expected to last a long time.
- Hospice care services for a terminally ill patient, as follows:
 - Room and board charges by the hospice, if it's not part of a hospital or skilled nursing facility;
 - Other medically necessary services and supplies;
 - Part-time nursing care, by or under the supervision of, a network registered graduate nurse (R.N.);
 - Home health care furnished in your home by a home health care agency for the following medically necessary services and supplies:
 - Part-time or intermittent nursing care by, or under the supervision of, a registered graduate nurse (R.N.);
 - Part-time or intermittent home health aide services consisting primarily of patient care; or
 - Physical therapy and occupational therapy;
 - Counseling services by a licensed social worker (or a licensed pastoral counselor if a hospice agency charge) for the patient and the patient's immediate family; and
 - Bereavement counseling services by a licensed social worker (or a licensed pastoral counselor) for the patient's immediate family, provided the services are included in the hospice care charges.

Services must be provided in an inpatient hospice facility or in your home. Counseling services received by the patient and the patient's immediate family in connection with hospice care will not be considered to have been received due to a mental health disorder.

For purposes of hospice care benefits, "patient's immediate family" is limited to you and your eligible dependents who are enrolled in your coverage under this Plan.

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- ✓ Extension of inpatient stays at a hospital, skilled nursing facility, authorized facility for mental health or substance abuse treatment may be considered, if medically necessary, but the extension request must be received and authorized by the Claims Administrator prior to the last previously authorized day of care.
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- Hospital charges in connection with hospitalization, as follows:
 - Semiprivate room and board in a qualified hospital (if a facility has private rooms only, the billed charge is allowed). Charges in excess of the semiprivate room rate are covered only if the patient is confined in a private room for such conditions as a severe burn or leukemia condition where there's significant danger of infection or for a contagious disease where a private room is required by the hospital or applicable law;
 - Necessary hospital services, such as lab tests, X-rays, medication, intensive care, operating room use and general nursing services;
 - General and special diets;
 - Sundries and supplies;
 - Ambulance services (emergency use only);
 - Administration of blood and blood products; and
 - Discharge planning.
- Mental health treatment or discussion with a mental health provider may be needed after a prolonged illness, death or strained relationship. The Claims Administrator's providers who specialize in mental health issues, such as depression, stress and anxiety, include:
 - Psychiatrists;
 - Psychologists;
 - Licensed social workers (Masters of Social Work);
 - Licensed professional counselors;
 - Licensed marriage and family therapists; and
 - Psychiatric nurses.

Inpatient treatment includes:

- Inpatient treatment in an authorized facility — including 24-hour residential treatment center care, and day and evening programs — which is covered under the Plan's hospital provisions.
- Covered hospital expenses and physician charges.

Inpatient treatment other than emergency care, and some outpatient services may require initial notification, pre-authorization and/or medical management/authorization.

Outpatient treatment includes:

- Psychotherapy;
- Marriage and family therapy;
- Psychiatric, psychological and medical laboratory testing; and
- Intensive outpatient treatment programs.
- Skilled nursing facility charges during your stay for the following services and supplies, up to the Plan maximums and subject to pre-authorization requirements:
 - Room and board, up to the semi-private room rate. Private room rate is covered if it is needed due to an infectious illness or a weak or compromised immune system;
 - Use of special treatment rooms;
 - Radiological services and lab work;
 - Physical, occupational, or speech therapy;
 - Oxygen and other gas therapy;
 - Other medical services and general nursing services usually given by a skilled nursing facility (this does not include charges made for private or special nursing, or physician's services); and
 - Medical supplies.

Does not include charges for treatment of mental health or substance use disorder, senility or mental retardation.

 "Pre-Authorization," page B-27

- Substance use disorder treatment is covered when the following conditions are met:
 - **In a non-emergency situation** — Benefits are available based on the Plan requirements. Some services may require initial notification, pre-authorization and/or medical management/authorization.
 - **In an emergency** — You can be admitted to any accredited hospital or treatment facility for emergency care. Treatment other than emergency care may require initial notification, pre-authorization and/or medical management/authorization.

Inpatient treatment includes:

- Inpatient treatment (including detoxification) in an authorized facility — including 24-hour residential treatment center care, and day and evening programs — which is covered under the Plan's hospital provisions.
- Covered hospital expenses and physician charges.

It is recommended that the first step in entering a treatment program is to contact the Claims Administrator.

 "Contacts," page A-1

The Claims Administrator will:

- Evaluate your needs;
- Design and obtain your agreement upon a treatment plan; and
- Refer you to appropriate network providers.

You will be offered a choice of authorized network providers, and it is up to you which authorized provider you use. The Claims Administrator can outline the requirements and potential risks in utilizing a non-network provider.


Outpatient treatment includes:

- Rehabilitation therapy and counseling;
- Marriage and family therapy;
- Psychiatric, psychological and medical laboratory testing; and
- Intensive outpatient treatment programs.

Pregnancy or Sexual Function

- Contraceptive expenses, as follows:
 - Charges incurred for contraceptive drugs and contraceptive devices that by law need a physician's prescription and that have been approved by the FDA; and
 - Related outpatient contraceptive services, such as consultations, exams, procedures and other medical services and supplies.

Not covered under the medical portion of the Plan are charges:

- For contraceptive drugs or self-injectables (self-administered) that are covered to any extent under the Retail Pharmacy or Mail Order/Maintenance Choice prescription drug programs;
 *"Prescription Drug Coverage," page B-39*
- Incurred for contraceptive services while you're confined as an inpatient; or
- For oral contraceptives or contraceptive patches that are covered under the Retail Pharmacy or Mail Order/Maintenance Choice prescription drug programs.

- Fertility treatment consisting of in-vitro fertilization and artificial insemination up to a lifetime maximum of \$30,000 (\$20,000 for medical services and \$10,000 for prescription drugs and injections). Contact the Claims Administrator for the criteria used to determine if the treatment is medically necessary.

 *"Contacts," page A-1*

- Pregnancy, childbirth and related medical conditions for the following covered individuals:
 - Covered female employees;
 - Covered dependent spouses/female domestic partners of employees; or
 - Covered female dependents of a covered employee. At the time of delivery, the dependent must be covered as a dependent.


Pregnancy expenses for a surrogate mother who isn't covered under the Plan are NOT covered.

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT – STATEMENT OF RIGHTS

Under federal law, group health plans offering group health 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 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, the Plan 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, the Plan 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're required to obtain pre-authorization for any days of confinement that exceeds 48 hours (or 96 hours). For information on pre-authorization, contact the Claims Administrator.


 *"Contacts," page A-1*

- Voluntary sterilization, as follows:
 - Routine uncomplicated vasectomy on an outpatient basis;
 - Routine uncomplicated laparoscopic tubal ligation on an outpatient basis; and
 - Tubal ligation and sterilization implants that are billed separately by the physician and the procedure was not the primary purpose of a confinement.

Prescription Drugs

- Prescription drugs as described on pages B-39 – B-46.
 “Prescription Drug Coverage,” page B-39

Surgery, Therapy, Medical and Physician Services

- Anesthetics and their administration (including the services of an anesthesiologist in connection with treatment in a hospital).
- Applied behavior therapy. Contact Claims Administrator for information.
 “Contacts,” page A-1
- Chemotherapy administration or medication.
- Dental treatment due to an accidental injury or diseases (such as jaw tumors or oral cancer) to teeth or the jaw. Covered dental expenses include charges made for dental work, surgery or orthodontic treatment needed to remove, repair, replace, restore or reposition:
 - Natural teeth damaged, lost or removed; or
 - Other body tissues of the mouth that were diseased, fractured or cut.

Injured teeth must have been:

- Free from decay or in good repair; and
- Firmly attached to the jawbone at the time of the injury.

If crowns, dentures, bridgework or in-mouth appliances are installed due to such injury, covered expenses include only charges for:

- The first denture or fixed bridgework to replace the lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of orthodontic treatment after the injury.

Coordination of benefits with the Employee Dental Plan doesn’t apply to charges resulting from an accidental injury.


 “Coordination of Benefits (COB),” page B-48


- Nutritional counseling that is medically necessary for chronic diseases for which dietary adjustment has a therapeutic role, if the nutritional counseling is prescribed by a physician and provided by a licensed health care provider recognized by the Claims Administrator.
- Physician (includes radiologists, anesthesiologists, pathologists) services for:
 - Preventive medical care and non-preventive medical care services and treatment (the Claims Administrator may need to be contacted to ensure ancillary charges by radiologists, anesthesiologists and pathologists are covered per Plan provisions);
 - Hospital, office and home visits; and
 - Emergency room services.
- Post-hospital services (i.e., charges made by a hospice or skilled nursing facility if you’re admitted as an inpatient). The need for these services must be authorized in writing by a physician. The maximum skilled nursing facility stay is 60 days per calendar year. **Custodial care isn’t covered.**
- Preventive medical care counseling services limits:
 - Obesity preventive counseling: Individuals younger than age 22 may have unlimited visits; individuals age 22 and over may have up to 26 visits every 12 months, of which up to 10 visits may be used for healthy diet counseling.
 - Tobacco preventive counseling is limited to 8 visits every 12 months.
 - Alcohol/Drug preventive counseling is limited to 5 visits every 12 months.

For preventive counseling, a session of up to 60 minutes is considered one visit.
- Preventive medical care services. See hr.conocophillips.com for coverage provisions and the Preventive Care Guide for additional information.
- Reconstructive surgery to ameliorate a deformity due to accidental injury, including:
 - Cosmetic surgery when it’s performed in conjunction with a staged reconstructive surgical procedure to improve or restore bodily function; and
 - Surgery to correct severe congenital (existing at birth) anomalies if it improves the function of a body part. This includes surgical correction of cleft lip (harelip), cleft palate, and webbed fingers or toes. **Surgery to correct congenital anomalies isn’t covered if the congenital anomalies don’t cause a functional impairment.**

The Plan does NOT cover surgery to correct a cosmetic disfigurement due to disease, unless:

- The disfigurement causes a functional impairment; or
- The surgical correction of the cosmetic disfigurement due to disease is performed in conjunction with a staged reconstructive surgical procedure to improve or restore bodily function.

 “The Women’s Health and Cancer Rights Act of 1998 (WHCRA),” page B-34

- Services from the Houston or The Well Onsite Medical Clinics.
- Short-term therapy, as described in the “Employee Medical Benefit Highlights” section. Contact the Claims Administrator for information regarding types of short-term therapy services and any applicable limits or restrictions.
 “Employee Medical Benefit Highlights,” page B-11;
“Contacts,” page A-1
- Speech therapy that’s medically necessary and expected to restore or enable speech to a person who has lost existing speech functions (the ability to express thoughts, speak words and form sentences) as a result of a disease, injury or a congenital defect for which corrective surgery has been performed. Also includes therapy to enable speech impaired by development delays, autism and hearing impairments, regardless of participant’s age. **Speech therapy for any other purpose is NOT covered.**
- Spinal manipulation performed, prescribed or recommended by any licensed practitioner, up to a maximum of 20 visits per calendar year.
- Surgery for obesity (bariatric surgery) only if certain medical conditions exist, medical therapies have been used and pre-authorization approval received from the Claims Administrator. You are encouraged to contact the Claims Administrator to request a listing of qualified providers before expenses are incurred. By contacting the Claims Administrator, you will be given information about specialized providers and discounts. **Bariatric surgery will only be covered when performed at a Blue Distinction Center.**
- X-rays and laboratory examinations made for diagnostic and treatment purposes or in connection with preventive medical care benefits. The Claims Administrator may need to be contacted to ensure ancillary charges by radiologists, anesthesiologists and pathologists are covered per Plan provisions.
- Walk-in clinic for non-emergency care.

Transportation

- Emergency transportation via professional ambulance service to transport you from the place you were injured or stricken by disease to the **nearest hospital that can provide the necessary care**. Charges for non-emergency professional ambulance service may also be covered for transportation from:
 - One hospital to another hospital in the area and back again when it’s documented that the first hospital doesn’t have the required services and/or facilities for treatment and certain criteria are met;
 - Hospital to skilled nursing facility, residential treatment center or nursing home when trained ambulance attendants are required to monitor your clinical status and you cannot be safely transported by any other means;
 - Home to hospital for medically necessary inpatient or outpatient treatment when trained ambulance attendants are required to monitor your clinical status and you cannot be safely transported by any other means.

The list of covered expenses on pages B-29 – B-34, although comprehensive, may not be all-inclusive. Other specific expenses may be determined to be covered consistent with other terms of the Plan.

THE WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the WHCRA. Since all of the medical options provide medical and surgical benefits for mastectomies, they must also provide coverage for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Coverage for prostheses (such as a breast implant); and
- Treatment for physical complications at all stages of the mastectomy, including lymphedema.


The same annual deductibles and annual out-of-pocket maximums apply to these procedures as apply to any other medical and surgical benefits provided under the Plan. If you would like more information on WHCRA benefits, call the Claims Administrator.

Non-Covered Expenses

While the Plan provides benefits for many medical services and supplies, some aren't covered. These exclusions include, **but aren't limited to:**

Ears, Eyes, Mouth

- Dental services (except charges for treatment of accidental injury to natural teeth, for a dentist's charges for consultation and X-rays done at the request of a physician).

 *"Dental Treatment Due to an Accidental Injury" bullet, page B-33*

- Dental prosthetic appliances or fittings thereof (except as may be required as a result of accidental injury to physical organs or parts).
- Appliances, restoration and procedures used in the treatment of jaw or cranial pain known as temporomandibular joint dysfunction (TMJ), myofascial pain dysfunction or craniomandibular pain syndrome.
- Vision care expenses, including:
 - Eyeglasses to correct impaired vision or fittings thereof;
 - Radial keratotomy to correct nearsightedness (myopia); or
 - Surgery to correct refractive errors.

Expenses Payable by Others

- Services furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.
- Services in connection with any injury or sickness that's sustained:
 - While doing any act or thing pertaining to any occupation or employment by an employer who is or should be covered under the provisions of any Workers' Compensation or similar law for which benefits are payable under said law or provision; or
 - As an employee of an employer that is not a company participating in the Plan.

- Services for confinement in a U.S. government or agency hospital. However, the reasonable cost incurred by the United States or one of its agencies for inpatient medical care and treatment given by a hospital of the uniformed services, Veterans Administration Facility or Military Treatment Facility may be covered under the Plan. If the cost for the care and treatment would normally have been a covered expense under this Plan, it will be covered for:

- An employee who is retired from the uniformed services;
- A family member of a person who is retired from the uniformed services;
- A family member of a person who is active in the uniformed services; or
- A family member of a deceased member of the uniformed services.

Any benefits paid under this provision will be paid to the U.S. government or appropriate agency and not to the participant.

- Services you would not be legally required to pay or not required to pay if there were no coverage. This includes charges for covered services provided by a member of your immediate family. Immediate family members include your spouse/domestic partner, son, daughter, domestic partner's children, father, mother, brother and sister.
- Services incurred by persons who aren't covered by the Plan.
- Services performed before Plan coverage begins or after coverage ends.
- Expenses you aren't required to pay due to discounts or other considerations given by the provider.
- Services and supplies furnished, paid for or for which benefits are provided or required under any law of a government. (This doesn't include a plan established by a government for its own employees or their dependents or Medicaid.)

Foot Care

- Foot orthotic devices, even if the attending physician provides a written prescription. Contact the Claims Administrator for medical conditions and devices that may be covered, such as those required for the treatment of or to prevent complications of diabetes or if the orthopedic shoe is an integral part of a covered brace.


Hospices, Hospitals, Home Care and Institutions

- Hospice care services provided by volunteers or individuals who don't regularly charge for their services, and/or for unlicensed hospice care.
- Hospice care services provided by a licensed pastoral counselor to a member of his or her congregation. These are services in the course of duties to which he or she is called as a pastor or minister.
- Education, training, and bed and board in an institution that's primarily a school or other institution for training, a place of rest, a place for the aged or a nursing home.
- Hospital expenses for private room accommodations in excess of the hospital's regular daily rate for semiprivate room accommodations (if a facility has private rooms only, the billed charge is allowed).
- Hospital expenses in excess of the cost of semiprivate room accommodations for private room accommodations for which benefits provided under Medicare are limited to the cost of semiprivate room accommodations.
- Home health care services or supplies that:
 - Aren't part of the home health care plan;
 - Are infusion therapy;
 - Are performed by a person who usually lives with you or is a member of your or your spouse's/domestic partner's family; or
 - Are for transportation.
- Halfway house expenses.


Not Medically Necessary or Reasonable

- Services and supplies that aren't medically necessary as determined by the Claims Administrator for the diagnosis, care or treatment of the disease or injury involved. This applies even if they're prescribed, recommended or approved by the person's attending physician or dentist.
- Procedures that would be unnecessary when performed in combination with other procedures.
- Diagnostic procedures that are unlikely to provide a physician with additional information when used repeatedly.
- Care, treatment, services or supplies that aren't prescribed, recommended and approved by the person's attending physician or dentist.

Pregnancy or Sexual Functions

- Reversal of a sterilization procedure.
- Surrogate mother's pregnancy expenses. See the "Dependent Eligibility" section to determine if the newborn child of a surrogate mother is an eligible dependent.
 *"Dependent Eligibility," page B-6*
- Therapy, supplies or counseling for sexual dysfunction or inadequacies that don't have a physiological or organic basis.

Prescription Drugs

- Prescription drug expenses for medications listed as non-covered in the prescription drug section.
 *"Non-Covered Medications and Supplies," page B-44*

Self-Inflicted Injuries

- Expenses resulting from self-inflicted injuries or from injuries that could foreseeably result from your behavior.

The Plan covers only charges to treat accidental injury. An accidental injury is commonly understood as one that's not expected and can't be foreseen. For example, if a person commits a felony, they have to expect or can certainly foresee that in the course of commission of that felony, they're likely to be injured by those who resist their attempts or by law enforcement. An injury that's expected or foreseeable isn't an accident, and therefore, it isn't covered by the Plan.

Another example would be so-called "aggressor" injuries, where someone covered under the Plan starts a fight and gets hurt. The Claims Administrator will deny coverage for treatment of this injury because it isn't an accident if the covered person gets hurt by someone defending himself against attack.

In general, self-inflicted injuries or injuries incurred during the commission of a felony aren't covered by the Plan. However, when such an injury is due to a physical or mental health condition or arose from an act of domestic violence, the injury will be covered. These situations will be evaluated on a case-by-case basis by the Claims Administrator.

Weight Loss

- Food supplements, such as those prescribed or provided as part of a weight loss/gain program.
- Fees for weight loss clinics or programs — except charges for specific services rendered by approved providers (e.g., physicians) **are** covered if certain medical conditions exist, medical therapies have been used and pre-authorization approval received from the Claims Administrator.


Other General Exclusions

- Services or supplies that are determined by the Claims Administrator to be investigational and/or experimental because they don't meet generally accepted standards of medical practice in the United States. This includes any related confinement, treatment, services or supplies. (See the box below.)

Some investigational and/or experimental drugs, devices, treatments or procedures are covered if **all** of the following conditions are met:

- You have been diagnosed with cancer or a condition likely to cause death within one year or less;
- Standard therapies have not been effective or are inappropriate;
- The Claims Administrator determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment; and
- You are enrolled in a clinical trial that meets these criteria:
 - The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
 - The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;
 - The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;
 - The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
 - You are treated in accordance with protocol.

- Care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
- Services of a resident physician or intern rendered in that capacity.
- Care that is predominantly custodial or domiciliary in nature, such as wilderness programs and military camps.
- Any testing, evaluation, consultation, therapy, services, supplies, or treatment for personal or professional growth and development.

- Services, treatment, education testing or training related to learning disabilities or developmental delays.
 - Academic education as a separate benefit during residential treatment.
 - Expenses for treatment of covered health care providers who specialize in the behavioral health field and who receive treatment as part of their training in that field.
 - Marriage, family, child, career, social adjustment, pastoral or financial counseling when the service is provided by someone who isn't recognized as a physician, psychologist or licensed counselor, social worker, or marriage and family therapist or when the treatment isn't related to a covered Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnosis.
 - Acupuncture therapy, except when performed by a physician as a form of anesthesia for surgery covered under the Plan.
 - Services for or related to the following types of treatment: Megavitamin therapy, bioenergetics therapy, vision perception training, carbon dioxide therapy, sleep therapy or massage therapy.
 - Expenses that exceed reasonable and customary limits as determined by the Claims Administrator (not applicable if a non-network charge is subject to the No Surprises Act).
 - Custodial care, as determined by the Claims Administrator.
 - Education, special education or job training, whether or not given in a facility that also provides medical or psychiatric treatment.
 - Allergy services and supplies that are non-standard, including, but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity and urine autoinjections.
 - Plastic surgery, reconstructive surgery, cosmetic surgery or other services and supplies that improve, alter or enhance appearance — whether or not for psychological or emotional reasons — except to the extent needed to improve the function of a part of the body that's not a tooth or structure that supports the teeth or that's malformed as a result of:
 - A severe birth defect, including harelip or webbed fingers or toes;
 - Mastectomy-related charges and breast augmentation when medically necessary;
 - Disease; or
 - Surgery performed to treat a disease or injury or to repair an injury.
 - Speech therapy, **except** for charges for speech therapy that's medically necessary and expected to restore or enable speech to a person who has lost existing speech functions (the ability to express thoughts, speak words and form sentences) as a result of a disease or injury or a congenital defect for which corrective surgery has been performed or speech impaired by development delays, autism and hearing impairments, regardless of participant's age.
 - Whirlpool or spas.
 - Performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically provided as described in this chapter.
 - Regular food products, such as food thickeners, baby food or other regular grocery products.
 - Travel expenses, unless prior approval is obtained by the Claims Administrator or you meet the criteria as outlined under the emergency transportation bullet under "Covered Expenses."
-  *"Emergency Transportation" bullet, page B-34*

The above list of non-covered expenses isn't all inclusive. Other specific expenses may be determined not to be covered consistent with other terms of the Plan.

Prescription Drug Coverage

All of the medical options include retail and mail order prescription drug benefits, provided through a Claims Administrator different than used for medical coverage.

Your cost for covered prescription drugs under each Plan option is as follows:

Plan Provision	HDHP Option ¹ : What You Pay	HDHP Base Option ¹ : What You Pay
Retail Pharmacy <i>Up to a 30-day supply</i> <i>For medication needed for short-term, acute or sudden conditions</i>	<p>If You Go to a Network Pharmacy</p> <p>You pay 100% until the <u>annual deductible</u> is met, then the Plan pays 80% and you pay 20% <u>coinsurance</u> until your <u>annual out-of-pocket maximum</u> (combined with medical expenses) is met. (Your minimum <u>coinsurance</u> amount per prescription is the lesser of your <u>coinsurance</u> or the pharmacy price for the medication.)</p> <p>100% coverage on eligible generic <u>preventive prescription drugs</u>² and insulin.</p> <p>If You Go to a Non-Network Pharmacy OR If You Fail to Show Your ID Card</p> <p>You'll pay the full price and will have to file a claim with the prescription drug <u>Claims Administrator</u> for reimbursement. You pay 100% until the <u>annual deductible</u> is met, then the Plan pays 60% of the prescription drug <u>Claims Administrator's</u> negotiated/discounted rate and you pay 40% <u>coinsurance</u> plus amounts above the negotiated/discounted rate.</p>	<p>If You Go to a Network Pharmacy</p> <p>You pay 100% until the <u>annual deductible</u> is met, then the Plan pays 80% and you pay 20% <u>coinsurance</u> until your <u>annual out-of-pocket maximum</u> (combined with medical expenses) is met. (Your minimum <u>coinsurance</u> amount per prescription is the lesser of your <u>coinsurance</u> or the pharmacy price for the medication.)</p> <p>If You Go to a Non-Network Pharmacy OR If You Fail to Show Your ID Card</p> <p>You'll pay the full price and will have to file a claim with the prescription drug <u>Claims Administrator</u> for reimbursement. You pay 100% until the <u>annual deductible</u> is met, then the Plan pays 60% of the prescription drug <u>Claims Administrator's</u> negotiated/discounted rate and you pay 40% <u>coinsurance</u> plus amounts above the negotiated/discounted rate.</p>
Mail Order/Maintenance Choice <i>Up to a 90-day supply</i> ³ <i>For long-term <u>maintenance medications</u> conducive to distribution in quantities greater than a 30-day supply</i>	<p>Mail Order/Maintenance Choice</p> <p>You pay 100% until the <u>annual deductible</u> is met, then the Plan pays 80% and you pay 20% <u>coinsurance</u> until your <u>annual out-of-pocket maximum</u> (combined with medical expenses) is met.</p> <p>100% coverage on eligible generic <u>preventive prescription drugs</u>² and insulin.</p>	<p>Mail Order/Maintenance Choice</p> <p>You pay 100% until the <u>annual deductible</u> is met, then the Plan pays 80% and you pay 20% <u>coinsurance</u> until your <u>annual out-of-pocket maximum</u> (combined with medical expenses) is met.</p>

¹ Any additional costs that you pay under the following Plan provisions will not apply to your annual deductible or annual out-of-pocket maximum.

- **Retail Refill Allowance** — You can obtain only the original 30-day fill and one 30-day refill at a retail pharmacy of a maintenance medication regardless of calendar year or receipt of a renewal prescription for the same maintenance medication. If a 30-day refill is not obtained via a Mail Order/Maintenance Choice option after the limit, you will pay 100% of the cost.
- **Brand/Generic Difference** — If you obtain a brand-name drug when an equivalent generic drug is available, you will pay 100% of the difference in cost. Only the cost of the equivalent generic drug will apply to your annual deductible or annual out-of-pocket maximum. This feature will apply regardless of whether you or your physician requests the brand-name drug.
- **Specialty Prescription Drugs** — If you do not obtain certain self-injectable or oral prescription drugs from the prescription drug Claims Administrator, you will pay 100% of the cost. Note: Coinurance amounts that are paid by a manufacturer coupon or rebate for Specialty Prescription Drugs will not apply to your annual deductible or annual out-of-pocket maximum.
- Prior Authorization, Preferred Drug Therapy and Quantity/Dose Limits.

² The annual deductible is waived on all eligible generic preventive prescription drugs and insulin.

³ Unless otherwise prohibited or modified by state law.

✓ Coordination of benefits (COB) doesn't apply to prescription drug benefits.

✓ Certain drugs such as aspirin, immunizations and contraceptives, if prescribed by a physician and meet the Health Care Reform eligibility criteria, are considered preventive medical care. These drugs are not subject to coinsurance, and are covered at 100%.

GENERIC VS. BRAND-NAME DRUGS

Prescription drugs usually fall into one of two basic categories — generic and brand name.

- A **generic drug** is therapeutically equivalent and contains the same active ingredients, in the same dosage form, as the brand-name drug.
- Brand-name drugs include preferred drugs and non-preferred drugs.
 - **Preferred drugs** include carefully selected brand-name drugs that can assist in maintaining quality care for patients, while helping to lower the cost of prescription drug benefits. The Claims Administrator has its own list of preferred drugs and can be contacted to determine if a prescribed medication is on the preferred list.
 - **Non-preferred drugs** are brand-name drugs that aren't on the prescription drug Claims Administrator's list of preferred drugs. Most non-preferred drugs cost more than preferred drugs.

See hr.conocophillips.com for the Claims Administrator's preferred drug list, which is called the **Performance Drug List**.

 “Contacts,” page A-1

For all of the options, your prescriptions will be filled with generic drugs whenever possible — even if the prescription is written for a brand-name drug. If you don't want a generic, you should have your physician instruct that the prescription is to be dispensed as written (DAW). This means the prescription will be dispensed as written with no substitutions. A DAW prescription may also require additional approval from the Claims Administrator or Benefits Committee.

If it is medically necessary and you obtain approval for a brand-name drug when an equivalent generic drug is available, you will pay 100% of the difference in cost. Only the cost of the equivalent generic drug will apply to your annual deductible or annual out-of-pocket maximum. This feature will apply regardless of whether you or your physician requests the brand-name drug.

Even if your physician does indicate the prescription is to be dispensed as written, the pharmacist may contact your physician if your prescription is unclear or incomplete, or to ask if a substitution or change may be made to the prescription. However, the pharmacist will not make any changes to your prescription unless authorized by your physician.

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- ✓ The Claims Administrator is authorized from time to time to include special coverage programs without charge to the Plan or to participants based on claims and medical trends to help control costs. Examples of such programs may include select coinsurance waivers or preferred drug therapy programs to facilitate a change to a lower-cost medication.
-

Retail Pharmacy Program

At a Network Pharmacy

You can purchase up to a 30-day supply of the prescription drug you need from any network pharmacy. Long-term maintenance medications are limited to one initial 30-day “fill” and one 30-day refill from a retail pharmacy, regardless of calendar year or receipt of a new prescription for the same maintenance medication. After you've had two fills of a long-term maintenance medication, you'll pay 100% of the cost of that medication unless you have it refilled through a Mail Order/Maintenance Choice option. Any cost you pay to refill a maintenance medication after the second fill will not apply to your annual deductible or annual out-of-pocket maximum unless filled through a Mail Order/Maintenance Choice option.

Just present your prescription benefits ID card when you have your prescription filled at a network pharmacy. You pay only your applicable coinsurance¹ at the time the prescription is filled. There are no claim forms to file.

¹ You have to meet the option's annual deductible (which includes medical expenses) before any Plan prescription drug benefits are paid (does not apply to certain eligible generic preventive prescription drugs and insulin under the HDHP option).


Non-Network Pharmacy/No ID Card

If you use a non-network pharmacy or if you fail to show your ID card at the time your prescription is filled, you'll pay 100% of the full (not discounted) cost of the medication and file a claim for reimbursement.

 “How to File a Claim,” page B-47

If you have met the respective option's annual deductible or annual out-of-pocket maximum, the Plan will reimburse you for your cost less your coinsurance (if applicable) and any amount above the negotiated/discounted rate. Note that because non-network pharmacies don't charge the negotiated/discounted costs, you'll generally pay more for prescriptions filled at non-network pharmacies.

✓ **To locate a network retail pharmacy:**

- Call the Claims Administrator's voice activated pharmacy locator system. This system is available 24 hours a day; or
 -  *"Contacts," page A-1*
 - Go to www.caremark.com and use the pharmacy locator function.
-

Mail Order/Maintenance Choice Program

The Mail Order/Maintenance Choice Program offers three options for individuals who are on maintenance medications or who will be on the same medication for a long period of time. You can choose to:

- Receive a 90-day supply of a maintenance medication by mail through the Claims Administrator's Mail Service Pharmacy;
 - Pick it up at a Claims Administrator's retail pharmacy; or
 - Pick it up at a Costco Pharmacy or one of the several independent pharmacies recognized by the Claims Administrator.
-

- ✓ Not all options of the Mail Order/Maintenance Choice Program are available in all states due to modifications or prohibitions by state laws. Amounts you pay due to state law limitations will be applied to your annual deductible and annual out-of-pocket maximum. Go to www.caremark.com and use the pharmacy locator function to see your options.
-

With Mail Order/Maintenance Choice the price you pay for a 90-day supply is the same regardless of the option you use. Mail order prescriptions may be filled with up to a 90-day supply and include free standard shipping.

For new prescriptions:

- Ask for two prescriptions: one for a long-term supply (e.g., 90 days) with as many as three refills (if appropriate) and the other for immediate short-term (e.g., 30 days) use. Have the short-term prescription filled at a network pharmacy.

- If using the Claims Administrator's Mail Service Pharmacy for the 90-day supply, complete the Claims Administrator's Mail Service Order Form. An incomplete form can cause a delay in processing. Mail your order form and original prescription to the Claims Administrator; or you can contact the Claims Administrator's FastStart Program. The FastStart representative will contact your physician for your mail order prescription after you have provided your ID number, mailing address, prescription drug name, and physician name and phone number.

 *"Contacts," page A-1*

- You can provide payment information when you place your order, or an invoice will be included with the prescription drug upon delivery. Payment for any order greater than \$100 must be received before your order will be processed. You can pay for your order by check, money order, credit or debit (check) card, or with your HSA card. Your medication will arrive approximately 10 to 14 calendar days after the Claims Administrator receives your order. Standard shipping is free-of-charge. You will receive a new mail service order form and envelope with each shipment.

For prescription drug refills:

- If using the Claims Administrator's Mail Service Pharmacy, you can order prescription drug refills by one of the following methods. The information included with your last order will show the date you can request a refill and the number of refills you have left.
 - **Online:** You will need to register with the Claims Administrator's website to access this service. Simply enter your ZIP code, date of birth, prescription drug number, and credit card information to order.
 - **By phone:** Call the toll-free number located on your prescription drug label for fully automated refill service. Have your ID number and credit card information ready.
 - **By mail:** Attach the refill label provided with your last order to a mail service order form. Enclose your payment with your order.

 *"Contacts," page A-1*

- ✓ **Prescriptions must be written by a U.S. provider and can be mailed only to an address in the U.S.**
-

- ✓ If you have questions about your specific prescription, call the Claims Administrator for information before you submit your original prescription. The Claims Administrator can answer questions about eligible medications, maintenance medications, filling prescriptions, your cost for a prescription drug, status of an order and any other matters on a prescription drug. Your coverage must be in force on the date the prescription is filled, not just on the date the order is placed.

 "Contacts," page A-1

The Company isn't involved in the preparation, delivery and packaging of pharmaceutical drugs under the program or day-to-day administration of the prescription drug benefit. If you experience these types of problems, contact the Claims Administrator for resolution.


 "Contacts," page A-1

- ✓ In addition to your prescription ID card, you will also receive an ExtraCare Health Card that can be used at CVS pharmacies to receive 20% off the purchase price of CVS store brand health-related items such as ibuprofen, allergy relief items, nasal decongestants, etc. If you have a CVS ExtraCare Rewards Card, contact the Claims Administrator to replace that card with this new card so you can obtain additional discounts.

 "Contacts," page A-1

Network Deficiency

A network deficiency is a situation in which the Claims Administrator doesn't have the prescribed medication available at a retail network pharmacy or by Mail Order/Maintenance Choice. A network deficiency doesn't exist if there's an appropriate network pharmacy within a reasonable driving distance (50 miles) of your home address. Prior approval from the Benefits Committee is required before any services by a non-network pharmacy can be deemed to be covered by network deficiency provisions and you may be required to take further action to obtain that approval. The Benefits Committee will not approve a network deficiency if there is a network pharmacy closer to your home than the non-network pharmacy for which you are requesting an exception.

 "Contacts," page A-1

Covered Medications and Supplies

Whether obtained through a retail pharmacy or through the Mail Order/Maintenance Choice program, prescription drugs are covered if they:

- Require a prescription for dispensing;
- Are approved by the U.S. Food and Drug Administration (FDA) and are prescribed by a physician licensed to practice medicine in the United States (including Puerto Rico); and
- Are medically necessary and are being used to treat a condition that's covered by the Plan.

The following chart shows which Claims Administrator to use for certain prescription drugs:

Prescription Drug	Claims Administrator to Use
Diabetic supplies, such as insulin syringes and insulin needles, lancets and test strips, are covered if prescribed by a <u>physician</u>	Prescription drug
Blood glucose monitors	Prescription drug
Continuous blood glucose monitors, insulin pumps and insulin supplies from a durable medical equipment supplier	Medical
Disposable insulin pumps	Prescription drug
Self-injection (self-administered) medications	Prescription drug
Infusions (must be administered in an infusion center, <u>hospital</u> or at home by a licensed health care professional)	Prescription drug or Medical
Certain self-injectable and oral specialty prescription drugs used to treat complex conditions and illness (excludes prescription drugs to treat diabetes)	Prescription drug's specialty pharmacy. ¹ Contact the <u>Claims Administrator</u> for a list of these medications. If you are on Medicare and it pays first, you will continue to obtain your specialty prescription drugs from the medical <u>Claims Administrator</u> .

¹ If you continue to purchase these medications from your doctor or another pharmacy, you will pay 100% of the cost. When you order a covered specialty medication through the Claims Administrator's specialty pharmacy, your out-of-pocket cost will be limited to the applicable (mail-order) coinsurance. Note: Coinurance amounts that are paid by a manufacturer coupon or rebate for Specialty Prescription Drugs will not apply to your annual deductible or annual out-of-pocket maximum.

Coverage Authorization (Prior Authorization), Preferred Drug Therapy and Quantity/Dose Limits

The Plan implements standards to ensure member health, safety and cost efficiencies. These standards may include: coverage authorization (prior authorization), use of another generic or similar preferred medication (preferred drug therapy), or quantity/dose limits (according to evidence-based clinical guidelines, FDA standards or health and safety limitations). **These standards may result in the Claims Administrator limiting payment through the Plan or managing the utilization of certain medications.** Some examples of medications managed by these standards include:

- Androgens and anabolic steroids;
- Appetite and weight loss agents;
- Antinarcotic agents;
- Antiemetic agents;
- CNS stimulants;
- Dermatologicals: Tretinoin topical/brand name minocycline;
- Select hypertensive agents (ARB);
- Hypnotic agents;
- Intranasal steroids;
- Long acting narcotic analgesics;
- Migraine therapy;
- Select antidepressant agents (Abilify); and
- Impotency medications.

Specialty medications including, but not limited to:

- Growth hormone;
- Cancer therapy;
- Immune globulins;
- Rheumatological agents;
- Endocrine agents (e.g., Acthar, Ceredase, Cerezyme, Kuvan);
- Specialty pulmonary agents (Xolair, HAE treatment, cystic fibrosis treatment, pulmonary arterial hypertension agents);
- Multiple sclerosis therapy;
- Myeloid and erythroid stimulants;
- Psoriasis treatment;
- Gout therapy; and
- Hepatitis C treatments.

Note for individuals using specialty medications:

The Plan is participating in the Claims Administrator's Specialty Guideline Management Program. This program supports safe, clinically appropriate and cost-effective use of specialty medications. The medications covered by this program are self-administered (outside of a physician's office) and may be either injectable or oral medications.

The Claims Administrator's Specialty Pharmacy is available to assist you with managing rare and complex conditions based on evidence-based medicine guidelines and consensus statements on appropriate use to assist in determining whether you should initiate therapy. Clinician-to-patient and clinician-to-physician consultations work through potential therapy issues. In-depth clinical reviews prior to and throughout the course of therapy ensure patient safety, efficacy and optional therapeutic benefit. NOTE: Some specialty medications may qualify for third party assistance programs which could lower your out-of-pocket costs for those products. For any such specialty medication where third party assistance is used, coinsurance amounts that are paid by a manufacturer coupon or rebate will not apply toward your annual deductible or annual out-of-pocket maximum.

Contact the Claims Administrator if you are starting a specialty medication, have questions whether your medication is a specialty medication, or need assistance with securing coverage or having claims processed.

All specialty medications must be approved by the Claims Administrator's Specialty Pharmacy Program in advance.

 *"Contacts," page A-1*

Non-Covered Medications and Supplies

Certain medications are generally not covered under the prescription drug benefit. These include, **but aren't limited to:**

- Drugs listed with preferred options on the Performance Drug List. Preferred options are listed as alternatives to the non-covered medications (subject to periodic changes). See hr.conocophillips.com for the Performance Drug List;

 *"Contacts," page A-1*

- Over-the-counter drugs and vitamins (those available without a prescription);
- Contraceptive implants, barrier contraceptives and spermicides (contraceptive jellies, creams, foams and devices) that are not FDA approved and are not prescribed by a physician;
- Mifeprex;
- Blood or blood plasma products;
- Nutritional and dietary supplements;
- Therapeutic devices or appliances (humidifiers, etc.);
- Drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine, Propecia) or that are for cosmetic purposes only rather than for treating a medical condition (e.g., Renova, Vaniqa, Tri-Luma, Botox-cosmetic, Avage Solage, Epiquin);
- Drugs labeled "Caution-limited by federal law to investigational use" or experimental drugs, even though a charge is made to the individual;
- Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law or any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the participant;

- Medication that's to be taken by, or administered to, an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution that operates a facility for dispensing pharmaceuticals on its premises or allows to be operated on its premises;
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order;
- Charges for the administration or injection of any drug;
- Any prescription drug for which there's an over-the-counter product with the same active ingredient;
- Homeopathics;
- Select compound medications;
- Ostomy supplies;
- Non-federal legend drugs; and
- Services or supplies that are determined by the Claims Administrator to be investigational and/or experimental. See page B-37 for further information regarding this exclusion.

Drugs to treat impotency (excluding Yohimbine) are covered for males age 18 and over only.

- The retail pharmacy benefit is limited to a 30-day supply or eight units per claim, whichever is less.
- The Mail Order/Maintenance Choice options are limited to a 90-day supply or 24 units per claim, whichever is less.

Lost or stolen prescription drugs will not be replaced by the Plan. In addition, the Plan will not reimburse you for out-of-pocket costs if a drug is lost or stolen.

Prescription drugs cannot be returned to the pharmacy after the prescription drug has been dispensed. In addition, the Plan will not reimburse you for out-of-pocket costs if a prescription drug has been released from the pharmacy.

Special Rules for Participants Living Outside the United States

While you (or one of your covered dependents) are living outside the United States, the prescriptions must be written by a U.S. physician and only will be shipped to a U.S. address. The Company will not ship medications to a non-U.S. address. Lost, stolen, confiscated or spoiled medicines are your responsibility.

If you know you're going to be outside the U.S. for an extended period of time, you should obtain your prescription drugs prior to leaving. You may receive up to a year's supply of drugs through the Mail Order/Maintenance Choice or Retail Pharmacy programs (if the prescription is written to allow up to a year's supply and the pharmacist agrees to a year's supply) by paying the appropriate coinsurance in the chart on page B-39.

✓ If you are going to obtain more than a 30-day supply by retail or a 90-day supply by mail, you must contact the Benefits Center **in advance** so your requested order can be filled. The same limits will apply as stated on the chart on page B-39 regarding your costs.

 "Contacts," page A-1

If an acute drug is needed while you're out of the U.S., you should purchase the drug outside the U.S. and submit the prescription drug Claims Administrator's claim form for reimbursement per the "Non-Network Pharmacy/No ID Card" section.

 "Non-Network Pharmacy/No ID Card," page B-40

For Participants Who Are Eligible for Medicare

The following provisions apply to a participant in the Plan who is eligible for Medicare Part D prescription drug coverage that began Jan. 1, 2006:

- The Company provides creditable prescription drug coverage in the Plan for all individuals who enroll. You don't have to enroll in a Medicare Part D prescription drug plan, but you may do so if you choose.
- There is no coordination of benefits between the Plan and Medicare with regard to prescription drug coverage. Participants will be able to have prescription drug coverage under either Medicare Part D or Medicare Part C with prescription coverage OR have medical and prescription drug coverage in the Plan. They cannot participate in both.

- Employees who choose to enroll in Medicare Part D prescription drug coverage or Medicare Part C with prescription coverage must contact the Benefits Center to cancel their medical and prescription drug coverage. You can cancel your covered dependent's coverage if he or she chooses to enroll in Medicare Part D prescription drug coverage or Medicare Part C with prescription coverage. If you or an eligible dependent decide to join a Medicare Part D prescription drug plan or Medicare Part C with prescription coverage and voluntarily drop ConocoPhillips medical and prescription drug coverage, be aware that you and your eligible dependents will not be able to get this coverage back until the next annual enrollment period unless you experience a change in status.
- If you don't enroll in Medicare Part D prescription drug coverage or Medicare Part C with prescription coverage or have other creditable prescription drug coverage, your Medicare Part D prescription drug premium will be permanently 1% higher for each month you're without creditable prescription drug coverage. Therefore, it's important for you to either continue to be covered by the Plan or to enroll in Medicare Part D prescription drug coverage or Medicare Part C with prescription coverage.
- The Company will provide you and your covered dependents that are eligible for Medicare with a Medicare creditable prescription drug coverage certificate upon your termination and each year thereafter. This certificate shows the periods in which you had creditable prescription drug coverage under the Plan. You should keep the certificate(s) in case you wish to enroll in a Medicare Part D prescription drug plan at a later date. This certificate will keep you from having to pay the penalty described above to enroll in a Medicare Part D prescription drug plan, as long as you and your dependents had continuous coverage in the Plan (including creditable prescription drug coverage) starting the day you and your dependents became eligible for Medicare.

- Plan participants can request a Medicare certificate of creditable prescription drug coverage by contacting the Benefits Center. This certificate shows the periods you had creditable prescription drug coverage in the Plan.
- Contact Medicare for questions regarding Medicare Part D prescription drug coverage at (800) 633-4227 (TTY communications device users should call (877) 486-2048) or go to www.medicare.gov.

 "Contacts," page A-1

U.S. Health Improvement Incentive Program

Incentive Program

Incentives will be paid as a payroll credit in 2025 (up to a maximum of \$1,050/year) and are available to employees enrolled in the Employee Medical Plan. See the Frequently Asked Questions available at hr.conocophillips.com for program details and materials to meet the requirements. The Plan may modify the requirements for the payroll credits to comply with Health Care Reform legislation.

You must have submitted the results of a biometric screening (completed either on-site or through your physician) by Sept. 30, 2024 or completed qualifying activities by Sept. 30, 2024 to be eligible to earn a Healthy Weight, Tobacco Free, Mental Wellbeing, Cholesterol and/or Blood Pressure incentive(s). Employees enrolled in the Expatriate Medical and Dental Plan do not need to meet the requirements to receive incentives.

The Healthy Weight incentive requires that you meet a Body Mass Index (BMI) measurement of less than 30. If your BMI is 30 or more, you must have completed a qualifying activity by Sept. 30, 2024 to earn the incentive.

The Blood Pressure incentive requires that you meet an incentive standard of a blood pressure less than 140/90. If your blood pressure is 140/90 or higher or just one of your systolic and diastolic numbers does not meet the criteria of less than 140/90, you must have reviewed the blood pressure material and complete the attestation by Sept. 30, 2024 to earn the incentive.

The Tobacco Free incentive requires certifying during your benefits enrollment that you are tobacco free.

The Cholesterol incentive requires that you meet an incentive standard of non-HDL cholesterol less than 130 mg/dl. If your non-HDL cholesterol is more than 130 mg/dl, you must have reviewed cholesterol material and complete a quiz by Sept. 30, 2024 to earn the incentive.

The Mental Wellbeing incentive requires that you have reviewed material from at least two focus areas on the Healthy Minds Platform or participated in at least one self-guided program through eMLife and completed the course attestation in MyLearning by Sept. 30 2024 to earn the incentive.

The Plan is committed to helping you achieve your best health status. If you think you might be unable to meet a standard for an incentive under this program, you might qualify for an opportunity to earn the same incentive by different means. Contact the Benefits Center, which will work with you to find a reasonable alternative with the same incentive that is right for you in light of your health status.

 *"Contacts," page A-1*

Improvement Programs

You and your covered dependents are eligible to participate in various health improvement programs at no cost to you. These programs are available on a voluntary basis:

- **Biometric Screenings** — Screenings that test your blood pressure, cholesterol, body mass and blood sugar. Screenings may be offered at work locations or through your personal physician.
- **Well-Being Management** — This program includes assistance for many complex conditions to lifelong wellness.

See the "Claims and Services" section of the "Contacts" chapter to see how to access more information.

 *"Contacts," page A-3*

How to File a Claim

If you go to a non-network provider or receive services while outside the U.S., you may have to pay for health care services at the time you receive them and then file a claim for reimbursement.

You may also need to file a claim for reimbursement if you purchase prescription drugs at a non-network pharmacy or don't show your ID card at the time you purchase your medication.


To file a claim for reimbursement, you'll need to submit the following to the Claims Administrator:

- A completed claim form; and
- All itemized bills indicating the date of service, description of service provided, diagnosis, name of the provider and charges incurred.

You can request claim forms from the Claims Administrator by phone or from their website. Claims should be returned to the Claims Administrator at the address listed in the "Contacts" chapter.

 "Contacts," page A-1

Slightly different procedures apply if you're making a pre-service claim or urgent care claim. For those claims, call the appropriate Claims Administrator. The Claims Administrator will assist you with your request for preapproval. The claim will be considered filed on the date you call the Claims Administrator.

 "Medical, Vision, Dental, FSP, Employee Assistance Plan, Houston Onsite Medical Clinic Plan and The Well Onsite Medical Clinic Plan Claims," page N-32

Claim Review and Appeal Procedure

For information about when to expect a response to your claim from the Claims Administrator and/or Appeals Administrator or how to file an appeal if your claim is denied, refer to the "Claims and Appeals Procedures" section.

 "Claims and Appeals Procedures," page N-26

✓ You don't need to file a claim if you go to a network provider for a covered expense. Your network provider will submit your claim to the Claims Administrator on your behalf.

✓ Medical claims must be received no later than 365 calendar days following the date the service was rendered. **For example, a claim dated March 1, 2025 must be received no later than March 1, 2026. Claims received after the deadline aren't eligible for payment under the Plan.**

Send your completed claims and supporting documentation to the Claims Administrator at the address shown under "Contacts."

 "Contacts," page A-1

Coordination of Benefits (COB)

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- ✓ Coordination of Benefits (COB) doesn't apply to prescription drug benefits.
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If you or a covered dependent have other group health coverage or Medicare — for instance, if your children are covered under your ConocoPhillips medical option and under your spouse's employer-provided medical plan — coordination of benefits (COB) is used to determine the portion of the expense paid by each plan. The ConocoPhillips medical options coordinate benefits with other group plans covering you and your dependents, including Medicare. The ConocoPhillips medical option always pays secondary to any medical payment, Personal Injury Protection (PIP) or No-Fault coverage provided under any automobile policy available to you.

When benefits are coordinated, certain rules are applied to determine which plan pays first (the “primary plan”), which pays second (the “secondary plan”) and, if there are three coverages, which pays third (the “tertiary plan”). The primary plan pays for coverage under its terms and doesn't take into account what is payable under a secondary or tertiary plan. However, total benefits payable from all plans cannot exceed 100% of the covered expense.

-
- ✓ The Employee Medical Plan uses “maintenance of benefits,” which is a form of COB. Under maintenance of benefits, if your ConocoPhillips coverage is the secondary plan and another plan covering you or a covered dependent is the primary plan, it's possible that the ConocoPhillips plan won't pay any benefits if the primary plan's benefits are equal to or better than the ConocoPhillips plan's benefits. The Plan limits benefits so that the total of all reimbursements will not exceed what the ConocoPhillips Plan would have paid. You're required to tell the Claims Administrator if you or your dependents have other coverage.
-

If an individual is covered under two or more plans, the order in which benefits shall be paid is as follows:


- A plan that doesn't have a coordination of benefits provision is the primary plan and determines its benefits first.
- The plan that covers the individual as an employee is primary; the plan covering the individual as a dependent is secondary.
- If you're covered by this Plan and your spouse/domestic partner is covered under another plan, special rules apply to dependent children covered under both plans:
 - In the case of domestic partnerships, the plan of the natural parent is primary.
 - In the case of married parents who aren't divorced or separated, the plan of the parent whose birthday (the month and day, not the year) falls earlier in the calendar year is primary. If both parents have the same birthday, the plan that has covered a parent longer is primary.
- When parents are separated or divorced, or terminating their domestic partnership and living apart, and the dependent children are covered by more than one plan, the following rules apply if there isn't a court order to the contrary:
 - The plan of the parent with custody of (or court ordered financial responsibility for) the dependent child is primary.
 - The plan of (1) the spouse of the parent with custody of the dependent child or (2) the domestic partner of the natural parent with custody of the dependent child is secondary.
 - The plan of the parent or domestic partner without custody (or court ordered financial responsibility) pays last.
- If you have COBRA continuation coverage, the COBRA coverage will be secondary to a plan that covers you as an employee (or as an employee's dependent).

 “COBRA Continuation Coverage,” page N-12

- The plan covering an individual as an employee (or as an employee's dependent) who is neither laid-off or retired is primary. The plan covering the individual as a laid-off or retired employee (or that individual's dependent) is secondary.
- If none of the above rules apply, the plan that has covered the individual longer is primary, and the plan that has covered the individual for less time is secondary.

Coordination With Medicare

Medicare becomes available on the first day of the month in which you reach age 65 — or the first day of the previous month if your birth date is the first of the month — whether you're retired or still working. Medicare also becomes available after you have been receiving Social Security disability benefits for two years or if you have been diagnosed with end-stage renal disease. **You must notify the Benefits Center if you or your covered dependent becomes eligible for Medicare prior to age 65.**

 "If You or a Dependent Becomes Eligible for Medicare," page B-7

Note: When Medicare is the primary plan and because the Plan assumes all covered expenses are eligible for Medicare whether or not the participant has actually enrolled in Medicare, the Plan will not pay charges for expenses that are eligible for Medicare Part A or B payment.

If you or your dependent becomes entitled to Medicare, Medicare is assumed to be the primary plan except in the following circumstances:

- Medicare is secondary for employees and their dependents age 65 and over who are covered by this Plan through the employee's status as an active employee with the Company.
- Medicare is secondary for employees and their dependents under age 65 who are entitled to Medicare on the basis of disability and who are covered under this Plan through the employee's status as an active employee with the Company.

- Medicare is secondary for 30 months for employees and their dependents under age 65 who are entitled to Medicare solely on the basis of end-stage renal disease (ESRD) and who are covered under this Plan as a result of the employee's status as an active employee with the Company. After 30 months the participant will no longer be eligible for this Plan and will be offered enrollment in the Retiree Medical Age 65 and Over Plan.

✓ For more information, refer to Working Aged Provision in the Glossary.

 "Glossary," page O-25



✓ **Note:** The Plan reserves the right to implement programs that allow for Medicare Part B-eligible prescription drug claims to be filed with Medicare for payment. If you take prescription drugs that can be covered by Medicare Part B, the prescription drug Claims Administrator will file a Medicare claim for the prescription drug. The Plan may be the secondary payer of these claims.

Annual Certification

Once every calendar year, the Claims Administrator will ask whether anyone in your family has medical coverage beyond that provided by this Plan. This helps keep costs down by ensuring that the Plan doesn't pay claims for which another party is responsible. You can complete online, or respond by mail or toll-free phone call. **You must respond to this annual questionnaire in order to have future claims paid.** Prompt responses will prevent delays in processing and paying claims.

When Coverage Ends


✓ If you become ineligible for coverage under the Plan, you may be eligible to continue coverage as follows:

- Through COBRA continuation coverage;
 “COBRA Continuation Coverage,” page N-12
- Through retiree coverage.
 Refer to the separate **Retiree Benefits Handbook** available from the Benefits Center or on hr.conocophillips.com

In the event of your death, your surviving spouse/domestic partner and eligible dependent children may be eligible for Retiree Medical coverage.

 “In the Event of Your Death,” page B-51

Your coverage will end on the earliest of the following events:

- The last day of the month in which your employment ends for any reason (excludes heritage Tosco former employees receiving long-term disability benefits with Plan eligibility designated on Company records whose coverage ends the earliest of either a) the last day of the month prior to Medicare eligibility due to age 65; or b) the last day of the month in which long-term disability benefits terminate);
- The last day of the month in which you no longer meet the Plan’s eligibility requirements;
 “Employee Eligibility,” page B-5
- The last day of the month in which your coverage is terminated for any other reason not stated in this section;
- The last day of the month in which you don’t pay the required cost for coverage;
- The last day of the month in which your leave of absence-Labor Dispute begins;
- If you have continued coverage during a leave of absence and you don’t return to work as an employee at the end of the leave, on the last day of the month in which the earliest of the following events occurs:
 - The leave expires; or
 - You first notify the Company that you don’t intend to return to work;

- The date of your death (see “In the Event of Your Death” for information about continued medical coverage for your surviving dependents); or

 “In the Event of Your Death,” page B-51

- The date on which the ConocoPhillips Employee Medical Plan is terminated.

Note: If coverage is terminated or lowered during the month, no reimbursements for any difference in medical coverage level are made for the month.

If you’re in the hospital on the day your coverage ends under the Plan and you’re not covered by another medical plan, the rest of the hospital stay will be covered by the Plan if:

- The hospitalization began before your coverage under the Plan ended; and
- Costs for Plan coverage were paid up to the date coverage ended.

If you’re in the hospital on the day your coverage under the Plan ends and you are covered by another medical plan, this Plan will pay benefits for the hospital stay through the last day of coverage and the other plan will be responsible thereafter.


Coverage for your covered dependent(s) ends on the earliest of the following events:

- The last day of the month in which your coverage ends for any reason;
- The date on which your dependent no longer qualifies as an eligible dependent as defined by the Plan.
Exception: A coverage loss due to a child dependent’s age or divorce/legal separation/annulment from spouse/dissolution of domestic partnership will occur the last day of the month in which the event occurred;
- The last day of the month in which coverage for your dependent(s) is terminated for any other reason not stated in this section;
- The last day of the month in which you don’t pay the required cost for dependent coverage;
- The date on which your dependent becomes eligible for coverage as a Company employee; or
- The date of your dependent’s death.

In the Event of Your Death

This section does **not** apply to the children of a domestic partner.

A surviving dependent who doesn't qualify for the survivor coverage — or who does qualify but chooses not to enroll in that coverage — may be eligible to continue coverage through COBRA.


 “COBRA Continuation Coverage,” page N-12

If you were an active employee, were on a leave of absence or were an under-age-65 heritage Tosco former employee receiving long-term disability benefits with eligibility designated on Company records at the time of your death, medical coverage for your surviving spouse/domestic partner and eligible dependent children who were enrolled as dependents under your coverage at the time of your death will continue until the last day of the month in which your death occurred. At that point, your dependents may be eligible to continue coverage through COBRA or through ConocoPhillips retiree medical coverage.

 “COBRA Continuation Coverage,” page N-12

If your surviving spouse and eligible dependent children **weren't** covered under a medical option on the date of your death, they'll be notified if they are eligible for the Retiree Medical Pre-Age 65 Plan or the Retiree Medical Age 65 and Over Plan and given the opportunity to enroll (surviving domestic partners will not be eligible to enroll if not covered on the date of your death). If eligible for coverage, the children (excluding children of the domestic partner) can enroll in retiree medical coverage regardless of whether your surviving spouse also enrolls.

Retiree medical coverage for your surviving spouse/domestic partner and eligible children can be the same coverage that you would have been eligible for as a retiree or long-term disability participant. Your survivor's cost is based on the 65-point rule (age plus years of service), using the greater of: (i) the points accrued by you under the 65-point rule during your lifetime; or (ii) 65 points. If the survivor was covered by the Retiree Medical Age 65 and Over Plan on Dec. 31, 2015, he or she may be eligible for a Company premium cost-sharing contribution. Any expenses that had been applied to your surviving spouse's/domestic partner's and eligible children's annual deductible, annual out-of-pocket maximum or lifetime maximum carry over, only upon request to the Claims Administrator, to their new Plan coverage (excluding the Retiree Medical Age 65 and Over Plan).

 “Annual Deductible,” page B-23; “Annual Out-of-Pocket Maximum,” page B-24

✓ For retiree medical eligibility provisions, coverage provisions and costs, refer to the separate *Retiree Benefits Handbook* available from the Benefits Center or on hr.conocophillips.com.

✓ If your surviving spouse/domestic partner is eligible for coverage under the Plan as an active employee, upon your death, he or she can choose to enroll in the Plan as an employee rather than as a surviving spouse/domestic partner.

 “Who Is Eligible,” page B-5

Your surviving spouse/domestic partner could then choose to cover his or her eligible dependent children as dependents under his or her coverage. In that event, there would be no break in coverage as long as coverage under the Plan is continuous.

Houston Onsite Medical Clinic Plan



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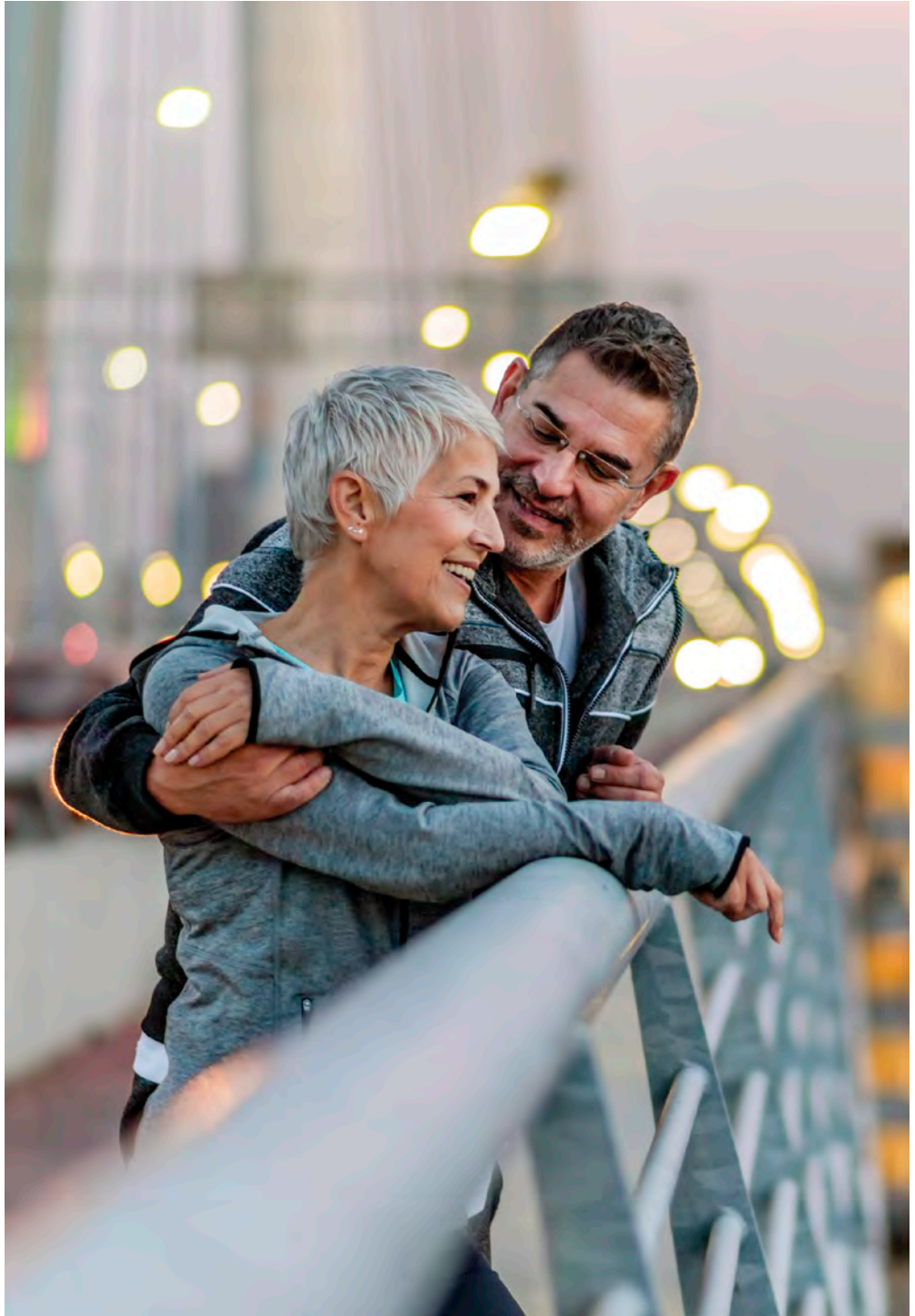
✓ Please refer to the Glossary beginning on page O-1 for the definitions of underlined terms used throughout this SPD.

 *"Glossary," page O-1*

In this chapter, the term "Company" is used to describe ConocoPhillips and the other companies whose employees are covered by this Plan.

Introduction

The ConocoPhillips Houston Onsite Medical Clinic Plan (the Plan) provides you and your family access to a full-service primary care clinic with services at fixed rates. The health and well-being of our employees and their families is a priority and we understand that busy schedules can make it difficult to schedule care. The onsite clinic provides a convenient and affordable option for medical care.



Who Is Eligible

Employee Eligibility

If you're an **active, regular full-time or regular part-time¹ employee**, you're eligible to participate in the Plan if you're:

- A U.S. citizen or resident alien employee working within the U.S. (includes rotators) who is paid on the direct U.S. dollar payroll²; or
- A U.S. citizen or resident alien employee working within the U.S. (includes rotators) who is paid on the direct U.S. dollar payroll² and who is on a leave of absence.
- An employee who is eligible for the Expatriate Medical and Dental Plan.

You're **not** eligible to participate in the Plan if your classification isn't described in this section. For example, temporary employees, intermittent employees, independent contractors, contingent workers, contract workers, leased employees and commission agents aren't eligible for the Plan.

Dependent Eligibility

Your eligible dependents may also be covered by this Plan. Eligible dependents include your:

- Spouse (including your state-recognized common-law spouse³; excluding a spouse after a divorce or separation by a legal separation agreement⁴) or your domestic partner; and
- Child, as follows:
 - Your biological, legally adopted (includes foreign adoptions) or placed for adoption child;
 - Your domestic partner's biological or legally adopted child (includes foreign adoptions), provided the child receives over 50% of his or her support from you and has the same principal place of abode as you for the tax year;
 - Your child under a legal guardianship agreement issued by a court; or
 - Your stepchild, provided the parent is your spouse and you and your spouse either remain married and reside in the same household or your spouse died while married to you.

You can cover the child/stepchild/guardianship child/domestic partner's child if he or she is:

- Under age 26⁵; or
- Age 26 or older, provided the child was disabled prior to age 26 and coverage is approved by the Plan within 30 calendar days of his or her reaching age 26 or initial eligibility after age 26⁶.

¹ Regular part-time employees must be regularly scheduled to work on average at least 20 hours per week.

² Direct U.S. dollar payroll means that payroll check is written in U.S. dollars by a U.S. company participating in the Plan and is not converted to another currency before being paid to the employee.

³ The common-law marriage must be consummated in a state that recognizes common-law marriage, and all state requirements must have been met.

⁴ The Plan will recognize a decree of legal separation or court-approved legal written separation agreement of any kind — including a court-approved separate maintenance agreement.

⁵ Your child is considered an eligible dependent up to age 26 regardless of student status, marital status, employment status and/or IRS dependent requirements.

⁶ A disabled dependent over age 26 who is disabled prior to age 26 may also become an eligible dependent if such disabled dependent experiences a qualified change in status and becomes eligible for the Employee Medical Plan.

Note: A dependent is **not** eligible if he or she:

- Is on active duty in any military service of any country (excluding weekend duty or summer encampments);
- Is not a U.S. citizen, resident alien or resident of Canada or Mexico;
- Is the child of a domestic partner and has been claimed as a dependent on your domestic partner's or on anybody else's federal tax return for the year of coverage;
- Is the child of a domestic partner and the domestic partnership between you and your domestic partner has ended, even if your domestic partner's child continues to reside with you;
- Is the child of a surrogate mother (is not considered the child of the egg donor) and does not qualify as a dependent otherwise;
- Is no longer your stepchild due to divorce, legal separation or annulment;
- Is a grandchild not legally adopted by you;
- Is placed in your home as a foster child; or
- Is in a relationship with you that violates local law.

Dependent Certification Rules

Accessing clinic services for an ineligible dependent or failure to provide required evidence of eligibility is considered by the Plan to be evidence of fraud and intentional misrepresentation of a material fact that will trigger rescission that may be back to the date on which your dependent no longer qualifies as an eligible dependent. If the coverage is rescinded, the Plan will give the participant a 30-calendar-day advance written notice prior to rescission. If you access clinic services for an ineligible dependent, the Plan has the right to request reimbursement of any claims or expenses paid for that dependent. In addition, you may be subject to disciplinary action — up to and including termination of coverage for benefits in this Plan or termination of employment by the employer for enrolling or keeping an ineligible dependent in the Plan.

Proof documenting dependent eligibility must be provided per rules, which may include requirements for self-certification in addition to documentation, adopted by the Benefits Committee. Failure to provide the certification and/or the requested documents verifying proof of dependent eligibility in a timely manner may delay or prevent your dependent's coverage, and you generally will not be able to have the coverage reinstated until the next annual enrollment period unless you experience a change in status event. If coverage is added at a later date, you will once again be asked to provide the appropriate documentation of dependent status. Contact the Benefits Center for details or if you have any questions about this requirement.

 "Contacts," page A-1

✓ All of the Plan's current services available at the clinic and the fixed rates charged for the services are available on hr.conocophillips.com.

 "Contacts," page A-1

How to Enroll

You don't need to enroll for this Plan. It begins automatically on the first date you meet the Plan's eligibility requirements.

 "Employee Eligibility," page C-3

What the Plan Costs

The Company pays the entire cost to participate in the Plan. As a participant, you have access to a full-service primary care clinic with services at fixed rates.

Houston Onsite Medical Clinic Plan Highlights

The clinic services are provided by onsite Memorial Hermann personnel. The clinic's schedule for patient visits will depend on demand and the clinic will be staffed by a licensed medical professional. Examples of services provided are:

- Allergy injection/antigen injections
- Annual physicals
- Biometric screenings
- Blood pressure checks
- Chronic disease management
- Electrocardiogram (EKG)
- In-office lab services
- Minor surgical procedures
- Nebulizer treatments
- Physical therapy with a prescription (a one-time evaluation can be completed without a prescription)
- Pulmonary function tests
- Routine immunizations
- School, sports or camp physicals
- Specialist referrals
- Travel medicine for required business travel
- Urgent care (same day acute issues)
- Well-woman exams

How the Houston Onsite Medical Clinic Plan Works

If possible, you should make an appointment for the services you need.

- If you are covered by the ConocoPhillips Employee Medical Plan, show your medical ID card so the clinic can file your claim for you. The clinic is in the Blue Cross and Blue Shield of Texas provider network. Any services you receive at the clinic will be covered 100% after your annual deductible. **Note:** Your ConocoPhillips Employee Medical Plan provisions will apply to any services you receive at the clinic and any amounts you pay will apply to your medical plan annual deductible and annual out-of-pocket maximum.
- If you are a participant in this Plan but not a participant in the ConocoPhillips Employee Medical Plan, you may choose to utilize this Plan and you will be billed for services you receive at the fixed Plan rates, but the clinic will **not** file Plan claims with other insurance.
- If you visit the clinic and prefer not to utilize this Plan, Memorial Hermann may contract with other insurance you have and file claims against that insurance. You will not receive the clinic's services at the Plan's fixed rates.
- If you are not a participant in this Plan, you will not be eligible for services at fixed Plan rates and you will be billed for services by the clinic at current-market rates.

 "Employee Medical," Page B-1

How to File a Claim

If you are enrolled in the Employee Medical Plan, you don't need to file a claim. The clinic will submit your claim to the Claims Administrator on your behalf. If you are not enrolled in the Employee Medical Plan, you will be billed and responsible to pay charges for services you receive at the clinic at the fixed Plan rates. You must be eligible for the Houston Onsite Medical Clinic Plan in order to have access to services at fixed Plan rates.



Claim Review and Appeal Procedure

For information about when to expect a response to your claim from the Claims Administrator and/or Appeals Administrator or how to file an appeal if your claim is denied, refer to the "Claims and Appeals Procedures" section.

 *"Claims and Appeals Procedures," page N-26*

When Coverage Ends

Your coverage will end on the earliest of the following events:

- The last day of the month in which your employment ends for any reason;
- The last day of the month in which you no longer meet the Plan's eligibility requirements;
 *"Employee Eligibility," page C-3*
- The date of your death (see "In the Event of Your Death" for information about continued medical coverage for your surviving dependents); or
 *"In the Event of Your Death," at right*
- The date on which the Houston Onsite Medical Clinic Plan is terminated.

Coverage for your covered dependent(s) ends on the earliest of the following events:

- The last day of the month in which your coverage ends for any reason;
- The date on which your dependent no longer qualifies as an eligible dependent as defined by the Plan.
Exception: A coverage loss due to a child dependent's age or divorce/legal separation/annulment from spouse/dissolution of domestic partnership will occur the last day of the month in which the event occurred;
- The date on which your dependent becomes eligible for coverage as a Company employee; or
- The date of your dependent's death.

In the Event of Your Death

If you were eligible for the Houston Onsite Medical Clinic Plan at the time of your death, your surviving spouse/domestic partner/eligible dependents will be eligible for the Houston Onsite Medical Clinic Former Employee Plan.

The Well Onsite Medical Clinic Plan

D

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✓ Please refer to the Glossary beginning on page O-1 for the definitions of underlined terms used throughout this SPD.

 “Glossary,” page O-1

In this chapter, the term “Company” is used to describe ConocoPhillips and the other companies whose employees are covered by this Plan.

Introduction

The ConocoPhillips The Well Onsite Medical Clinic Plan (the Plan) provides you and your family access to a full-service primary care clinic with services at fixed rates. The health and well-being of our employees and their families is a priority and we understand that busy schedules can make it difficult to schedule care. The onsite clinic provides a convenient and affordable option for medical care.



Who Is Eligible

Employee Eligibility

If you're an **active, regular full-time or regular part-time¹ employee**, you're eligible to participate in the Plan if you're:

- A U.S. citizen or resident alien employee working within the U.S. (includes rotators) who is paid on the direct U.S. dollar payroll²; or
- A U.S. citizen or resident alien employee working within the U.S. (includes rotators) who is paid on the direct U.S. dollar payroll² and who is on a leave of absence.
- An employee who is eligible for the Expatriate Medical and Dental Plan.

You're **not** eligible to participate in the Plan if your classification isn't described in this section. For example, temporary employees, intermittent employees, independent contractors, contingent workers, contract workers, leased employees and commission agents aren't eligible for the Plan.

Dependent Eligibility

Your eligible dependents may also be covered by this Plan. Eligible dependents include your:

- Spouse (including your state-recognized common-law spouse³; excluding a spouse after a divorce or separation by a legal separation agreement⁴) or your domestic partner; and
- Child, as follows:
 - Your biological, legally adopted (includes foreign adoptions) or placed for adoption child;
 - Your domestic partner's biological or legally adopted child (includes foreign adoptions), provided the child receives over 50% of his or her support from you and has the same principal place of abode as you for the tax year;
 - Your child under a legal guardianship agreement issued by a court; or
 - Your stepchild, provided the parent is your spouse and you and your spouse either remain married and reside in the same household or your spouse died while married to you.

You can cover the child/stepchild/guardianship child/domestic partner's child if he or she is:

- Age 2 to age 26⁵; or
- Age 26 or older, provided the child was disabled prior to age 26 and coverage is approved by the Plan within 30 calendar days of his or her reaching age 26 or initial eligibility after age 26⁶.

¹ Regular part-time employees must be regularly scheduled to work on average at least 20 hours per week.

² Direct U.S. dollar payroll means that payroll check is written in U.S. dollars by a U.S. company participating in the Plan and is not converted to another currency before being paid to the employee.

³ The common-law marriage must be consummated in a state that recognizes common-law marriage, and all state requirements must have been met.

⁴ The Plan will recognize a decree of legal separation or court-approved legal written separation agreement of any kind — including a court-approved separate maintenance agreement.

⁵ Your child is considered an eligible dependent up to age 26 regardless of student status, marital status, employment status and/or IRS dependent requirements.

⁶ A disabled dependent over age 26 who is disabled prior to age 26 may also become an eligible dependent if such disabled dependent experiences a qualified change in status and becomes eligible for the Employee Medical Plan.

Note: A dependent is **not** eligible if he or she:

- Is on active duty in any military service of any country (excluding weekend duty or summer encampments);
- Is not a U.S. citizen, resident alien or resident of Canada or Mexico;
- Is the child of a domestic partner and has been claimed as a dependent on your domestic partner's or on anybody else's federal tax return for the year of coverage;
- Is the child of a domestic partner and the domestic partnership between you and your domestic partner has ended, even if your domestic partner's child continues to reside with you;
- Is the child of a surrogate mother (is not considered the child of the egg donor) and does not qualify as a dependent otherwise;
- Is no longer your stepchild due to divorce, legal separation or annulment;
- Is a grandchild not legally adopted by you;
- Is placed in your home as a foster child; or
- Is in a relationship with you that violates local law.

Dependent Certification Rules

Accessing clinic services for an ineligible dependent or failure to provide required evidence of eligibility is considered by the Plan to be evidence of fraud and intentional misrepresentation of a material fact that will trigger rescission that may be back to the date on which your dependent no longer qualifies as an eligible dependent. If the coverage is rescinded, the Plan will give the participant a 30-calendar-day advance written notice prior to rescission. If you access clinic services for an ineligible dependent, the Plan has the right to request reimbursement of any claims or expenses paid for that dependent. In addition, you may be subject to disciplinary action — up to and including termination of coverage for benefits in this Plan or termination of employment by the employer for enrolling or keeping an ineligible dependent in the Plan.

Proof documenting dependent eligibility must be provided per rules, which may include requirements for self-certification in addition to documentation, adopted by the Benefits Committee. Failure to provide the certification and/or the requested documents verifying proof of dependent eligibility in a timely manner may delay or prevent your dependent's coverage, and you generally will not be able to have the coverage reinstated until the next annual enrollment period unless you experience a change in status event. If coverage is added at a later date, you will once again be asked to provide the appropriate documentation of dependent status. Contact the Benefits Center for details or if you have any questions about this requirement.

 *"Contacts," page A-1*

✓ All of the Plan's current services available at the clinic and the fixed rates charged for the services are available on hr.conocophillips.com.

 *"Contacts," page A-1*

How to Enroll

You don't need to enroll for this Plan. It begins automatically on the first date you meet the Plan's eligibility requirements.

 *"Employee Eligibility," page D-3*

What the Plan Costs

The Company pays the entire cost to participate in the Plan. As a participant, you have access to a full-service primary care clinic with services at fixed rates.

The Well Onsite Medical Clinic Plan Highlights

The clinic's schedule for patient visits will depend on demand and the clinic will be staffed by a licensed medical professional. Examples of services provided are:

- Allergy injection/antigen injections
- Annual physicals
- Biometric screenings
- Blood pressure checks
- Chronic disease management
- Electrocardiogram (EKG)
- In-office lab services
- Minor surgical procedures
- Nebulizer treatments
- Prescription for physical therapy
- Pulmonary function tests
- Routine immunizations
- School, sports or camp physicals
- Specialist referrals
- Travel medicine for required business travel
- Urgent care (same day acute issues)
- Well-woman exams

How The Well Onsite Medical Clinic Plan Works

If possible, you should make an appointment for the services you need.

- If you are covered by the ConocoPhillips Employee Medical Plan, show your medical ID card so the clinic can file your claim for you. Any services you receive at the clinic will be covered 100% after your annual deductible. **Note:** Your ConocoPhillips Employee Medical Plan provisions will apply to any services you receive at the clinic and any amounts you pay will apply to your medical plan annual deductible and annual out-of-pocket maximum.
- If you are a participant in this Plan but not a participant in the ConocoPhillips Employee Medical Plan, you may choose to utilize this Plan and you will be billed for services you receive at the fixed Plan rates, but the clinic will **not** file Plan claims with other insurance.
- If you are not a participant in this Plan, you will not be eligible for services.



"Employee Medical," Page B-1

How to File a Claim

If you are enrolled in the Employee Medical Plan, you don't need to file a claim. The clinic will submit your claim to the Claims Administrator on your behalf. If you are not enrolled in the Employee Medical Plan, you will be billed and responsible to pay charges for services you receive at the clinic at the fixed Plan rates. You must be eligible for The Well Onsite Medical Clinic Plan in order to have access to services at fixed Plan rates.

Claim Review and Appeal Procedure

For information about when to expect a response to your claim from the Claims Administrator and/or Appeals Administrator or how to file an appeal if your claim is denied, refer to the "Claims and Appeals Procedures" section.



 "Claims and Appeals Procedures," page N-26

When Coverage Ends

✓ If you become ineligible for coverage under the Plan, you may be eligible to continue coverage through COBRA Continuation Coverage.

 "COBRA Continuation Coverage," page N-12

Your coverage will end on the earliest of the following events:

- The last day of the month in which your employment ends for any reason;
- The last day of the month in which you no longer meet the Plan's eligibility requirements;
 "Employee Eligibility," page D-3
- The date of your death (see "In the Event of Your Death" for information about continued medical coverage for your surviving dependents); or
 "In the Event of Your Death," at right
- The date on which The Well Onsite Medical Clinic Plan is terminated.

Coverage for your covered dependent(s) ends on the earliest of the following events:

- The last day of the month in which your coverage ends for any reason;
- The date on which your dependent no longer qualifies as an eligible dependent as defined by the Plan.
Exception: A coverage loss due to a child dependent's age or divorce/legal separation/annulment from spouse/dissolution of domestic partnership will occur the last day of the month in which the event occurred;
- The date on which your dependent becomes eligible for coverage as a Company employee; or
- The date of your dependent's death.

In the Event of Your Death

If you were eligible for The Well Onsite Medical Clinic Plan at the time of your death, your surviving spouse/domestic partner/eligible dependents will continue to be eligible until the last day of the month in which your death occurred. At that point, your dependents may be eligible to continue coverage through COBRA.

 "COBRA Continuation Coverage," page N-12

Employee Vision Plan



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✓ Please refer to the Glossary beginning on page O-1 for the definitions of underlined terms used throughout this SPD.

📄 “Glossary,” page O-1

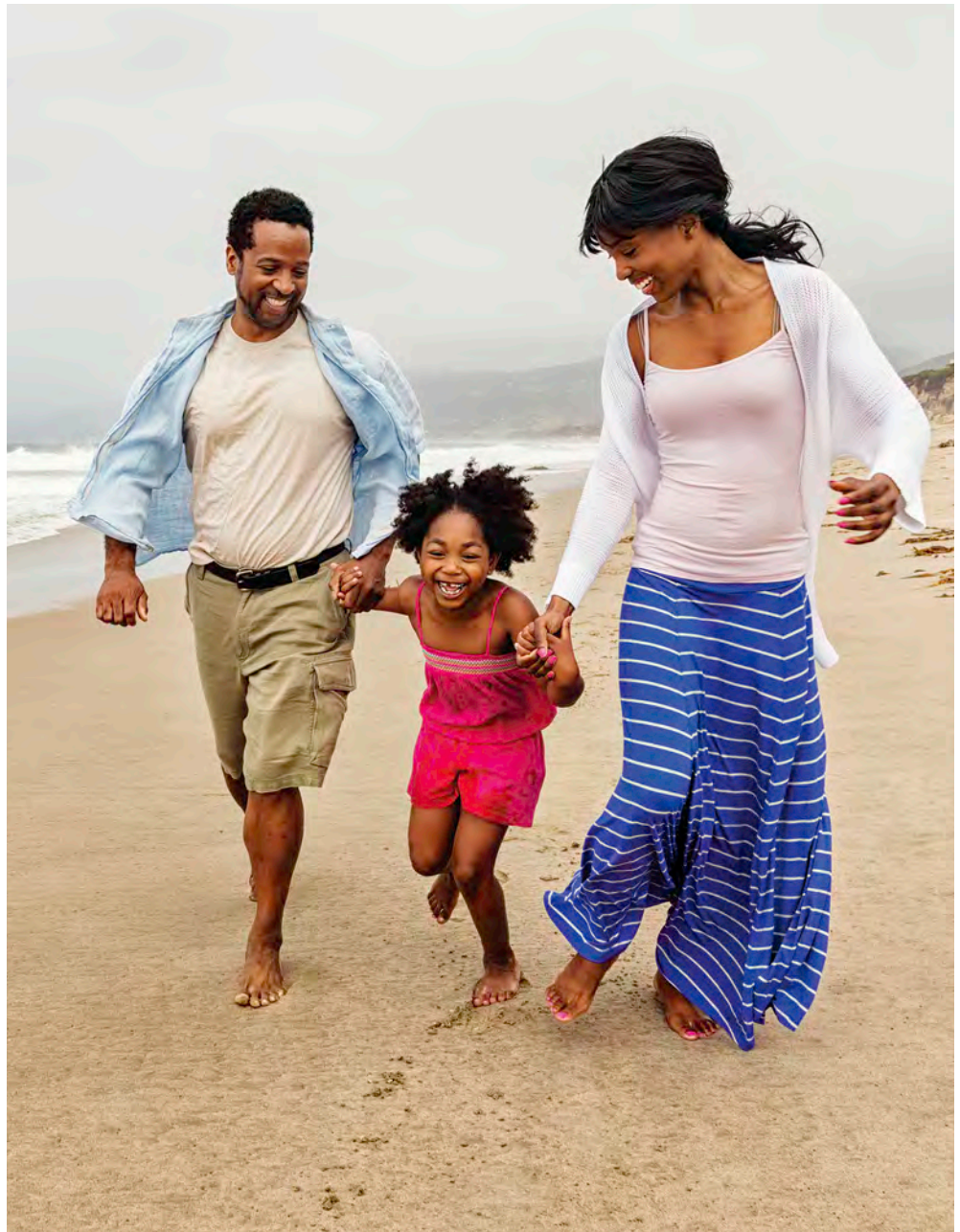
In this chapter, the term “Company” is used to describe ConocoPhillips and the other companies whose employees are covered by this Plan.

Introduction

The ConocoPhillips Employee Vision Plan (the Plan) provides you and your family with coverage for regular vision checkups and other services to keep your eyes healthy.

You may be eligible for the following vision options:

- The Vision Base option provides basic coverage for exams and prescription glasses/contact lenses and eyewear discounts; and
- The Vision Plus option provides enhanced coverage for exams and prescription glasses/contact lenses and eyewear discounts.



Who Is Eligible

EMPLOYEES ELIGIBLE FOR THE EXPATRIATE MEDICAL AND DENTAL PLAN

Employees eligible for the Expatriate Medical and Dental Plan **are not** eligible for the Employee Vision Plan.


Employee Eligibility


If you're an active, regular full-time or regular part-time¹ employee, you're eligible to participate in the Plan if you're:

- A U.S. citizen or resident alien employee working within the U.S. (includes rotators) who is paid on the direct U.S. dollar payroll²; or
- A U.S. citizen or resident alien employee working within the U.S. (includes rotators) who is paid on the direct U.S. dollar payroll² and who is on a personal, disability or military leave of absence or on a family medical leave of absence.

You're **not** eligible to participate in the Plan if your classification isn't described in this section. For example, temporary employees, intermittent employees, independent contractors, contingent workers, contract workers, leased employees and commission agents aren't eligible for the Plan.


Note: Special rules apply if your spouse/domestic partner is also a Company employee or retiree.

 "If Your Eligible Dependent Is Also a Company Employee or Retiree," at right

 Contact the Benefits Center for questions about whether your collective bargaining agreement expressly provides for your participation in the Plan.

 "Contacts," page A-1

If Your Eligible Dependent Is Also a Company Employee or Retiree

 Review the rules used in determining dependent eligibility under the Plan.

 "Dependent Eligibility," page E-4

If you have an eligible dependent (spouse/domestic partner, dependent child) who is also **employed by ConocoPhillips**, neither you nor any eligible dependent can be covered by more than one Company vision option. Dual coverage is prohibited even if the other vision option is union-sponsored vision coverage.

If both you and your spouse/domestic partner are employed by ConocoPhillips, your election is considered to be a separate election from your spouse's/domestic partner's election and cannot be changed during the calendar year unless a change in status occurs (e.g., you get divorced, gain or lose a dependent, change in job status, etc.).

 "Changing Your Coverage," page E-7

If your spouse/domestic partner is a **ConocoPhillips retiree**, he or she can be covered as a dependent under your vision coverage.

¹ Regular part-time employees must be regularly scheduled to work on average at least 20 hours per week.

² Direct U.S. dollar payroll means that payroll check is written in U.S. dollars by a U.S. company participating in the Plan and is not converted to another currency before being paid to the employee.

Dependent Eligibility

If you enroll in the Plan, your eligible dependents may also be enrolled for coverage. Eligible dependents include your:

- Spouse (including your state-recognized common-law spouse¹; excluding a spouse after a divorce or separation by a legal separation agreement²) or your domestic partner; and
- Child, as follows:
 - Your biological, legally adopted (includes foreign adoptions) or placed for adoption child;
 - Your domestic partner's biological or legally adopted child (includes foreign adoptions), provided the child receives over 50% of his or her support from you and has the same principal place of abode as you for the tax year;
 - Your child under a legal guardianship agreement issued by a court; or
 - Your stepchild, provided the parent is your spouse and you and your spouse either remain married and reside in the same household or your spouse died while married to you.

You can cover the child/stepchild/guardianship child/domestic partner's child if he or she is:

- Under age 26³; or
- Age 26 or older, provided the child was disabled prior to age 26 and coverage is approved by the Plan within 30 calendar days of his or her reaching age 26 or initial eligibility after age 26⁴.

¹ The common-law marriage must be consummated in a state that recognizes common-law marriage, and all state requirements must have been met.

² The Plan will recognize a decree of legal separation or court-approved legal written separation agreement of any kind — including a court-approved separate maintenance agreement.

³ Your child is considered an eligible dependent up to age 26 regardless of student status, marital status, employment status and/or IRS dependent requirements.

⁴ A disabled dependent over age 26 who is disabled prior to age 26 may enroll in the Plan (i) during annual enrollment or (ii) if such disabled dependent experiences a qualified change in status.

Note: A dependent is **not** eligible if he or she:

- Is on active duty in any military service of any country (excluding weekend duty or summer encampments);
- Is not a U.S. citizen, resident alien or resident of Canada or Mexico;
- Is already covered under a Company vision plan as an employee or as a dependent (including COBRA participants);
- Is the child of a domestic partner and has been claimed as a dependent on your domestic partner's or on anybody else's federal tax return for the year of coverage;
- Is the child of a domestic partner and the domestic partnership between you and your domestic partner has ended, even if your domestic partner's child continues to reside with you;
- Is the child of a surrogate mother (is not considered the child of the egg donor) and does not qualify as a dependent otherwise;
- Is no longer your stepchild due to divorce, legal separation or annulment;
- Is a grandchild not legally adopted by you;
- Is placed in your home as a foster child; or
- Is in a relationship with you that violates local law.


Dependent Certification Rules

When you enroll your eligible dependent(s) in the Plan and when you continue their participation at each annual enrollment, you represent the following:

- The individual is eligible under the terms of the Plan; and
- You will provide evidence of eligibility on request.

Enrolling an ineligible dependent **or** not cancelling coverage within 30 calendar days of when an eligible dependent ceases to meet the Plan's dependent eligibility requirements **or** failure to provide required evidence of eligibility is considered by the Plan to be evidence of fraud and intentional misrepresentation of a material fact that will trigger rescission that may be back to the date on which your dependent no longer qualifies as an eligible dependent. If the coverage is rescinded, the Plan will give the participant a 30-calendar-day advance written notice prior to rescission. The Plan has the right to request reimbursement of any claims or expenses paid for an ineligible dependent. If canceling your ineligible dependent's coverage reduces your cost for coverage, any amounts you have overpaid will not be refunded. In addition, you may be subject to disciplinary action — up to and including termination of coverage for benefits in the applicable Plan or termination of employment by the employer for enrolling or keeping an ineligible dependent in the Plan.

Proof documenting dependent eligibility must be provided per rules, which may include requirements for self-certification in addition to documentation, adopted by the Benefits Committee. Failure to provide the certification and/or the requested documents verifying proof of dependent eligibility in a timely manner may cause termination of your dependent's coverage, and you generally will not be able to reinstate coverage until the next annual enrollment period unless you experience a change in status event described in the "Changing Your Coverage" section. If coverage is reinstated you will once again be asked to provide the appropriate documentation of dependent status. Contact the Benefits Center for details or if you have any questions about this requirement.

 "Contacts," page A-1; "Changing Your Coverage," page E-7

How to Enroll, Change or Cancel Coverage

If you want to enroll in vision coverage for yourself or your eligible dependents, you enroll online or call the Benefits Center. Your enrollment materials will contain information to help you make your enrollment elections. If you have questions about the enrollment procedure or need more information, contact the Benefits Center.

 "Contacts," page A-1

When you enroll, you'll:

- Choose from the Plan options available to you;
- Decide which of your eligible dependents you wish to cover, if any; and
- Authorize any required payroll deductions for the cost of the coverage you select.

✓ Your medical, vision and dental enrollment elections are separate — meaning you can enroll for vision coverage regardless of whether you're enrolled in medical or dental coverage, and vice versa. In the same way, you can choose to enroll different dependents in your vision coverage than in your medical or dental coverage.

Note: The vision Claims Administrator does **not** issue ID cards, but one can be obtained from the Claims Administrator's website.

 "Contacts," page A-1

When to Enroll, Change or Cancel Coverage

You can enroll, change or cancel Plan coverage:

- When you become eligible as a new employee;
- When you become eligible due to a change in your employee classification;
- During annual enrollment; or
- If you have a change in status.

 “Changing Your Coverage,” page E-7

-
- ✓ After your initial eligibility for the Plan, you can enroll only during annual enrollment unless you have a change in status during the year. A disabled dependent over age 26 who is disabled prior to age 26 may enroll in the Plan (i) during annual enrollment or (ii) if such disabled dependent experiences a qualified change in status.
-

When Coverage Begins

The date coverage for you and/or your eligible dependents begins depends on the event and on when you enroll.

For the following event:	If an enrollment action is made with the Benefits Center:	The coverage change effective date is:
Employees newly hired or newly eligible to participate.	Within 30 calendar days after the event ¹	The date of the event
Annual enrollment	Within the annual enrollment period	The following Jan. 1
When you have a change in status	See “Changing Your Coverage” on page E-7 for information	See “Changing Your Coverage” for information
When you add a new <u>eligible dependent</u> due to birth, adoption or <u>placement for adoption</u>	Within 90 calendar days after the event ¹	The date of the event
When you return to work as a regular full-time or regular part-time employee on or before the expiration of a <u>leave of absence</u> (if a loss of coverage occurred during the leave)	Within 30 calendar days after the event ¹	The date of the event
When you return to work as a regular full-time or regular part-time employee on or before the expiration of a <u>leave of absence</u> -Labor Dispute (if a loss of coverage occurred during the leave and the leave was 30 calendar days or less)	No enrollment action is required; coverage will be reinstated automatically	The date of the event
When you return to work as a regular full-time or regular part-time employee on or before the expiration of a <u>leave of absence</u> -Labor Dispute (if a loss of coverage occurred during the leave and the leave was more than 30 calendar days)	Within 30 calendar days after the event ¹	The date of the event

¹ If an enrollment action is not made within the allowable number of calendar days after the event, you won't be able to make the enrollment action until the next annual enrollment period (absent another enrollment event), with coverage effective the first of the following calendar year.

-
- ✓ If you're a surviving spouse/domestic partner or eligible child, see “In the Event of Your Death.”

 “In the Event of Your Death,” page E-16

Changing Your Coverage

Because you pay for coverage on a before-tax basis, IRS rules limit when you can make changes to your coverage. Other than during each year's annual enrollment, you can change your coverage election only if you experience a change in status for which you may be required or allowed to make changes to your coverage. The coverage election must be consistent with your change in status, and you cannot make a coverage change for financial reasons or because a provider stops participating in a network.

Because coverage change effective dates vary based on the event and the date of your enrollment action, contact the Benefits Center for further information about when the coverage change will be effective. To make changes, enroll online or call the Benefits Center.



"Contacts," page A-1

"Change in status" changes may include these life events:

- Your marriage, divorce, legal separation or annulment;
- Death of an eligible dependent;
- Addition of an eligible dependent through birth, adoption, legal guardianship or placement for adoption. (Even if you already have *You + Two or More* coverage, you need to enroll your new eligible dependent(s) in order for their coverage to take effect);
- A relocation or move outside of the U.S. and/or network's coverage area;
- Loss of coverage;
- A Qualified Medical Child Support Order that requires you to provide vision coverage for a child;
- A change in employment status by you or your eligible dependent;
- A change in work schedule by you or your eligible dependent that changes coverage eligibility;
- A change in your eligible dependent's status;
- You and/or your eligible dependents become eligible for and enroll in or lose eligibility for Medicare or Medicaid;
- You and/or your eligible dependents become entitled to COBRA;
- The taking of or return from a leave of absence under the Family Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act of 1994; and

- You or your eligible dependents have a significant change in benefits or costs, such as benefits from another employer, etc.

If you don't report the change to the Benefits Center within 30 calendar days (90 calendar days to add a new eligible dependent due to birth, adoption or placement for adoption) after the event date:

- **You won't be able to change coverage until the next annual enrollment period; and**
- **The change won't be effective until the first of the following calendar year.**

The Benefits Committee shall have the exclusive authority to determine if you're entitled to revoke an existing election as a result of a change in status or a change in the cost or coverage, as applicable, and its determination shall bind all persons.




If a relocation back to the U.S. or a transfer to the U.S. payroll initiates eligibility for this Plan or if your vision option is eliminated, your coverage will automatically be the Vision Base option unless you enroll otherwise.

If You Take a Leave of Absence

If you're on a leave of absence, you may continue coverage for yourself and your eligible dependents during the approved leave period — provided you pay any required costs for coverage when they're due.

- During your leave, you pay the same cost for coverage that an active employee would pay.
 - If you're on a paid leave, your cost for coverage will continue to be deducted from your paycheck on a before-tax basis.
 - If you're not receiving a paycheck from the Company, you'll pay the cost for coverage to ConocoPhillips on an after-tax basis. (ConocoPhillips will bill you for the cost for coverage.)
- When you return to work, the Company will resume deducting the cost for coverage from your paycheck on a before-tax basis.

If you end your coverage while you're away on leave — or if your coverage is ended due to non-payment of required costs for coverage — you must meet the same criteria as an active employee if you want to re-enroll in the Plan upon your return to work.

 “Who Is Eligible,” page E-3; “How to Enroll, Change or Cancel Coverage,” page E-5

✓ If You're on a Military Leave of Absence

See “USERRA Continuation Coverage” for general information regarding your vision coverage while you're on a military leave of absence.

 “USERRA Continuation Coverage,” page N-20

If You Have a Leave of Absence-Labor Dispute

If you're placed on a leave of absence-Labor Dispute, coverage for you and your eligible dependents will end on the last day of the month in which the leave begins. You may continue coverage for yourself and your eligible dependents during the leave under COBRA provisions. See the chart on page E-6 for coverage after you return to work. If you are on a leave of absence-Labor Dispute during a regularly scheduled annual enrollment, you won't be eligible and a special annual enrollment period will be provided after you return from the leave of absence-Labor Dispute.

What the Plan Costs

You pay the total cost of your vision coverage with before-tax dollars. Your cost for coverage for yourself and your eligible dependents is based on the Plan option and level of coverage you elect, regardless of your scheduled workweek hours (regular full-time or regular part-time).

Your cost for coverage is automatically deducted from your paycheck on a before-tax basis, which means that your taxable pay is lower — and so is the amount you pay for Social Security and Medicare taxes, federal income tax and, in most areas, state and local income tax. Your enrollment authorizes the deductions to be taken from your paycheck on a before-tax basis.


The Benefits Committee reserves the right to recover any underpayments by the employee or eligible dependent, made through error or otherwise, by offsetting future payments, invoicing the affected participant or by other means as the Benefits Committee deems appropriate.

When you enroll, you'll receive information about how to access the current costs for each of your available Plan options and levels of coverage.

✓ **The Benefits Committee has authority to make temporary changes in Plan provisions as appropriate, at the Benefits Committee's discretion, to respond to a natural or man-made emergency or disaster so participants can obtain covered services and benefits. In any such instance, the Benefits Committee shall adopt administrative procedures specifying the changes and the duration of such changes.**

Employee Vision Benefit Highlights

The benefits provided by the vision options from Vision Service Plan Insurance Company (VSP) are discussed in the chart below. **Note:** Limitations apply to some Plan benefits. See “Covered Expenses” and “Non-Covered Expenses” for additional information.

 “Covered Expenses,” page E-13; “Non-Covered Expenses,” page E-13

Plan Provision	Vision Base Option		Vision Plus Option	
	Network ¹	Non-Network	Network ¹	Non-Network
<u>Annual deductible</u>	None	None	None	None
<u>Well vision exam (one per calendar year)</u>	100% covered	Reimbursed up to \$45	100% covered	Reimbursed up to \$45
Lenses (every calendar year)²				
Single vision	100% covered	Reimbursed up to \$30	\$20 <u>copay</u> ³	Reimbursed up to \$30
Lined bifocal	100% covered	Reimbursed up to \$50	\$20 <u>copay</u> ³	Reimbursed up to \$50
Lined trifocal	100% covered	Reimbursed up to \$65	\$20 <u>copay</u> ³	Reimbursed up to \$65
Lenticular	100% covered	Reimbursed up to \$100	\$20 <u>copay</u> ³	Reimbursed up to \$100
Progressive — standard	100% covered	Reimbursed up to \$50	100% covered	Reimbursed up to \$50
Progressive — premium or custom	30% average savings	Reimbursed up to \$50	\$40 <u>copay</u>	Reimbursed up to \$50
Impact Resistant (for <u>eligible dependent children</u>)	100% covered	Not covered	100% covered	Not covered
Impact Resistant (for adults)	30% average savings	Not covered	30% average savings	Not covered
Contact lenses ⁴ (only the discount is available if allowance used on frames)	\$130 allowance ⁵ for contacts and the contact lens exam (fitting and evaluation) ⁶ 15% off exam thereafter	Reimbursement up to \$105	\$200 allowance ⁵ for contacts and the contact lens exam (fitting and evaluation) ⁶ 15% off exam thereafter	Reimbursement up to \$105
Annual allowance ⁵	One pair of eyeglass frames or contact lenses — not both. Additional discounts may apply.		One pair of eyeglass frames or contact lenses — not both. Additional discounts may apply.	

See footnotes on page E-11.

(continued)

✓ If you're enrolled in the Expatriate Medical and Dental Plan, please refer to the materials provided by the Claims Administrator for information about your vision coverage.

✓ The list of Plan benefits should address most services and treatments. Limitations and exclusions may apply to some services. However, if you have additional questions about a specific service, you should call the Claims Administrator.

 “Contacts,” page A-1

Plan Provision	Vision Base Option		Vision Plus Option	
	Network ¹	Non-Network	Network ¹	Non-Network
Frames				
Frames for children (<i>one per calendar year</i>) ²	\$130 allowance ⁵ , 20% discount thereafter	Reimbursed up to \$100	\$20 <u>copay</u> ³ , \$200 allowance ⁵ , 20% discount thereafter	Reimbursed up to \$100
Frames for adults (Base — <i>one every other calendar year</i> ; Plus — <i>one per calendar year</i>)	\$130 allowance ⁵ , 20% discount thereafter	Reimbursed up to \$100	\$20 <u>copay</u> ³ , \$200 allowance ⁵ , 20% discount thereafter	Reimbursed up to \$100
Lens Options				
Photochromic	30% average savings	Not covered	\$30 <u>copay</u>	Not covered
Anti-reflective coating	30% average savings	Not covered	\$40 <u>copay</u>	Not covered
Scratch resistant coating	30% average savings	Not covered	30% average savings	Not covered
Tints	30% average savings	Not covered	30% average savings	Not covered
Low Vision Testing ⁷ (<i>visual problems not corrected with regular lenses</i>)	100% covered	Reimbursed up to \$125	100% covered	Reimbursed up to \$125
Supplemental care aids for low vision	25% <u>coinsurance</u>	25% <u>coinsurance</u> ⁸	25% <u>coinsurance</u>	25% <u>coinsurance</u> ⁸
Other Services — Available Through VSP Only				
Laser surgery	Average 15% off the regular price or 5% off the promotional price. Discounts only available through VSP contracted facilities.			
Sunglasses	20% off from any <u>network provider</u> within 12 months of your exam.			
Hearing aids	TruHearing provides an average discount of 25% on hearing aids. VSP enrolled members and dependents have free access to this discount program.			

¹ Should you receive services from a network provider without a VSP benefit authorization, you are responsible for payment in full to the provider and filing of a claim for the charges eligible for reimbursement.

² An eligible dependent child may be eligible for an additional exam, frame, pair of lenses or contact lenses in a calendar year per the schedule of benefits any time they have one of these significant changes: new prescription differs from the original by at least a .50 diopter sphere or cylinder, a change in the axis of 15 degrees or more, or there is a .5 prism diopter change in at least one eye.

³ One copay required when purchasing either frames or lenses or both.

⁴ Contact lens are covered when VSP benefit criteria are met and verified by a VSP network provider for eye conditions that would prohibit the use of glasses, such as aphakia, aniridia, anisometropia, corneal transplant, high ametropia, nystagmus, keratoconus and hereditary corneal dystrophies.

⁵ Allowance for frames (if eligible for frames) or contacts, but not both.

⁶ The contact lens exam (fitting and evaluation) is a separate exam from the well vision exam and is also known as the fitting and evaluation to ensure the proper fit of contact lens.

⁷ The maximum allowable benefit for low vision testing and aids is \$1,000 every two-calendar years, with a maximum of two supplemental tests within a two-year period. Services must be prescribed by a provider. Low vision benefits are available to covered persons who have severe visual problems that are not correctable with regular lenses.


⁸ 75% reimbursement will not exceed what VSP would pay a network provider.

How the Employee Vision Plan Works

The Plan gives you a **choice** when accessing your vision care. You can go to:

- Any participating network provider (if available) optometrist or ophthalmologist who has agreed to:
 - Charge participants a contracted VSP Choice fee, which is usually lower than those charged by non-network providers and is not subject to reasonable and customary provisions; and
 - File the vision claims for you; or
- A non-network provider. Services received from non-network providers **are** subject to reasonable and customary provisions.

The Plan provides a wide range of vision services and products regardless of whether you use a network provider or a non-network provider.

 “Employee Vision Benefit Highlights,” page E-10;
“Covered Expenses,” page E-13

-
- ✓ When you contact a network provider, you must identify yourself as a VSP member so the provider can obtain a benefit authorization from VSP prior to your appointment. VSP will pay the provider direct for services provided per the benefit schedule. Should you receive services from a network provider without such benefit authorization or obtain services from a non-network provider, you are responsible for payment in full to the provider and for filing a claim for the charges eligible for reimbursement. Coverage provisions are the same for emergency and non-emergency conditions.
-

To Find a Network Provider

- Ask your provider if he or she is in the VSP Choice network.
- Access the Claims Administrator’s website for network information, or call the Claims Administrator and get the information over the phone.

 “Contacts,” page A-1

It’s your responsibility to ensure that you use VSP Choice network providers if you want to receive the benefit of lower, contracted and discounted rates.

Keep in mind that network providers occasionally change and that some areas don’t have network providers, so you’ll want to make sure the provider you choose is still in the VSP Choice network before you make an appointment. For the most up-to-date information, including whether a provider is accepting new patients, call the provider directly.

Note: Not all retail chain providers are in the VSP Choice network. There may be some retail chain providers who will bill the Claims Administrator directly for plan benefits, however, providers may be unable to provide all the plan benefits. Retail chain providers can be found on the Claims Administrator’s website or by contacting the Claims Administrator. You should discuss coverage level, if any, of requested services with the retail chain provider or the Claims Administrator in advance.

 “Contacts,” page A-1

Important Plan Features

If You’re Outside the United States

If you require covered vision services while traveling outside the United States on pleasure or business, the cost will be covered as a non-network expense according to the rules of the Plan. In order to be covered, the services from any provider outside the U.S. must have been received from a licensed optometrist, optician or ophthalmologist or other licensed and qualified vision care provider. You should:

- Pay for the services received;
- If possible, have the bill translated into English; and then
- Submit a claim form, in the currency of the country in which the licensed provider is located, to the Claims Administrator for reimbursement.

 “Contacts,” page A-1

Covered Expenses

The Vision Base and Plus options cover exams and prescription glasses/contact lenses and eyewear discounts for vision needs rather than cosmetic materials, as described on the Benefit Highlights chart.

 “Employee Vision Benefit Highlights,” page E-10

Non-Covered Expenses

While the Plan provides benefits for many vision services and supplies, some are not covered. These exclusions include (unless stated as covered or discounted in the specific vision option), **but are not limited to:**

- Some brands of spectacle frames;
- Optional cosmetic services or materials;
- Color coating;
- Mirror coating;
- Scratch coating;
- Blended lenses;
- Cosmetic lenses;
- Laminated lenses;
- Oversize lenses;
- Certain limitations on low vision care; and
- Professional services or materials connected with:
 - Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ± 5.50 diopter power); or two pair of glasses in lieu of bifocals;
 - Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available;
 - Medical or surgical treatment of the eyes;
 - Corrective vision treatment of an experimental nature;
 - Retail membership fees that include access to affiliate providers; and
 - Costs for services and/or materials above plan benefit provisions.

The above list of non-covered expenses isn’t all inclusive. Other specific expenses may be determined not to be covered consistent with other terms of the Plan.

Essential Medical Eye Care

The supplemental Essential Medical Eye Care is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the Plan, eyecare professionals provide treatment and management of urgent and follow-up services. Essential Medical Eye Care also involves management of conditions that require monitoring to prevent future vision loss and may provide additional benefits. Any medical services not paid by your medical coverage (or if the covered person doesn’t have medical coverage) will be considered for payment under Essential Medical Eye Care.

If eligible for this program, additional benefits from a VSP network provider are:

- Retinal screening for members with diabetes, \$0 copay;
- Additional exams and services for members with diabetes, glaucoma, or age-related macular degeneration, \$20 per exam;
- Treatment and diagnoses of eye conditions, including pink eye, vision loss and cataracts, available for all members, \$20 per exam;
- Diabetic eye examination covered in full after a \$20 copay (covered up to \$100 after a \$20 copay if by a non-network provider); and
- Special ophthalmological services covered in full (covered up to \$120 per service if by a non-network provider).

Non-covered expenses under this program are:

- Frames, lenses, contact lenses or any other ophthalmic materials;
- Orthoptics or vision training and any associated supplemental testing;
- Surgery of any type, and any pre- or post-operative services;
- Treatment for any pathological conditions;
- An eye exam required as a condition of employment;
- Insulin or any medications or supplies of any type; and
- Local, state and/or federal taxes, unless VSP is required to pay by law.

Contact the Claims Administrator or a VSP network provider to discuss eligibility for this program.

 “Contacts,” page A-1

How to File a Claim

-
- ✓ You don't need to file a claim if you go to a network provider for a covered expense. Your network provider will submit your claim to the Claims Administrator on your behalf.
-

If you're enrolled in the Plan and go to a network provider, you must identify yourself as a VSP member so the doctor can obtain a benefit authorization from VSP **prior to your appointment**. VSP will pay the provider directly for services provided per the benefit schedule.

If you're enrolled in the Plan and go to a non-network provider or receive services from a network provider who didn't obtain a benefit authorization from VSP, you'll have to pay the full fee for vision care services at the time you receive them and then file a claim for reimbursement of eligible charges. To do so, you'll need to submit the following to the Claims Administrator:

- A completed claim form; and
- All itemized bills, indicating the date of service, description of service provided, diagnosis, name of the provider and charges incurred.

You can request claim forms from the Claims Administrator. **Note:** See "If You're Outside the United States" for information on filing a claim for services received outside the U.S.


 "If You're Outside the United States," page E-12

-
- ✓ Send your completed claims and supporting documentation to the Claims Administrator at the address shown under "Contacts."

 "Contacts," page A-1

-
- ✓ **Vision claims must be received within 365 days of the date of service.** Claims received after the 365-day deadline are not eligible for payment under the Plan.
-

Slightly different procedures apply if you're making a pre-service claim or urgent care claim. For those claims, call the appropriate Claims Administrator. The Claims Administrator will assist you with your request for preapproval. The claim will be considered filed on the date you call the Claims Administrator.

 "Medical, Vision, Dental, FSP, Employee Assistance Plan, Houston Onsite Medical Clinic Plan and The Well Onsite Medical Clinic Plan Claims," page N-32

Claim Review and Appeal Procedure

For information about when to expect a response to your claim from the Claims Administrator and/or Appeals Administrator or how to file an appeal if your claim is denied, refer to the "Claims and Appeals Procedures" section.

 "Claims and Appeals Procedures," page N-26

Coordination of Benefits

Essential Medical Eye Care

If a covered person is approved for Essential Medical Eye Care, a claim will need to be filed first with the covered person's group medical insurance coverage, if any, and then to the vision Claims Administrator. Any amount not paid by the medical plan will be considered for payment by the vision Claims Administrator per coordination of benefits provisions.

Coverage Under Multiple Vision Plans

If you or a covered dependent has other group vision coverage, coordination of benefits (COB) is used to determine the portion of the expense paid by each plan. The ConocoPhillips Employee Vision Plan coordinates benefits with other group plans covering you and your dependents.


When benefits are coordinated, certain rules are applied to determine which plan pays first (the “primary plan”), which pays second (the “secondary plan”) and, if there are three coverages, which pays third (the “tertiary plan”). The primary plan pays for coverage under its terms and doesn’t take into account what is payable under a secondary or tertiary plan. However, total benefits payable from all plans cannot exceed 100% of the covered expense.

If an individual is covered under two or more plans, the coordination of benefit provisions are as follows:



- A plan that covers the participant as an employee is the primary plan.
- A plan that covers the participant as a dependent is the secondary plan.
- If the patient is an eligible dependent child and is covered under both parents’ plans, typically the parent whose birthdate falls first in the calendar year has the primary plan. If the parents are separated or divorced, the parent with custody is primary, unless otherwise ordered by the court.
- When VSP administers the secondary plan, the participant will receive a specified allowance for each service (exam, lenses, frame or contacts) that will be used to pay up to, but not more than, the billed amount. Only services received on the primary benefit may be used for coordinating like services on the secondary benefit. Secondary allowances are applied first to the same service of the primary plan. Any remaining amount may be used to cover additional expenses on other services.
- If a non-network provider provides the services, VSP will reimburse the participant according to each benefit’s non-network schedule of allowances, not to exceed the actual exam fee and the cost of corrective eyewear.

When Coverage Ends

- ✓ If you become ineligible for coverage under the Plan or in the event of your death, your surviving spouse/domestic partner and eligible dependent children may be able to continue coverage through COBRA continuation coverage.

 “COBRA Continuation Coverage,” page N-12; “In the Event of Your Death,” page E-16

Your coverage will end on the earliest of the following events:

- The last day of the month in which your employment ends for any reason;
- The last day of the month in which you no longer meet the Plan’s eligibility requirements;
 “Employee Eligibility,” page E-3
- The last day of the month in which your coverage is terminated for any other reason not stated in this section;
- The last day of the month in which you don’t pay the required cost for coverage;
- The last day of the month in which your leave of absence-Labor Dispute begins;
- If you have continued coverage during a leave of absence and you don’t return to work as an employee at the end of the leave, on the last day of the month in which the earliest of the following events occurs:
 - The leave expires; or
 - You first notify the Company that you don’t intend to return to work;
- The date of your death (see “In the Event of Your Death” for information about continued vision coverage for your surviving dependents); or
 “In the Event of Your Death,” page E-16
- The date on which the ConocoPhillips Employee Vision Plan is terminated.

Note: If coverage is terminated or lowered during the month, no reimbursements for any difference in vision coverage level are made for the month.

-
- ✓ When a benefit authorization is provided by VSP to the provider and services are performed prior to the expiration date of the benefit authorization, you are eligible for the benefits even if your coverage terminated prior to conclusion of the services.
-

Coverage for your covered dependent(s) ends on the earliest of the following events:

- The last day of the month in which your coverage ends for any reason;
- The date on which your dependent no longer qualifies as an eligible dependent as defined by the Plan.
Exception: A coverage loss due to a child dependent's age or divorce/legal separation/annulment from spouse/dissolution of domestic partnership will occur the last day of the month in which the event occurred;
- The last day of the month in which coverage for your dependent(s) is terminated for any other reason not stated in this section;
- The last day of the month in which you don't pay the required cost for dependent coverage;
- The date on which your dependent becomes eligible for coverage as a Company employee; or
- The date of your dependent's death.

In the Event of Your Death

If you were an active employee or were on a leave of absence, vision coverage for your surviving spouse/domestic partner and eligible dependent children who were enrolled as dependents under your coverage at the time of your death will continue until the last day of the month in which your death occurred. At that point, your dependents may be eligible to continue coverage through COBRA.

 "COBRA Continuation Coverage," page N-12

-
- ✓ If your surviving spouse/domestic partner is eligible for coverage under a ConocoPhillips plan as an active employee, upon your death, he or she can choose to enroll in one of those plans as an employee rather than as a surviving spouse/domestic partner.

 "Who Is Eligible," page E-3

Your surviving spouse/domestic partner could then choose to cover his or her eligible dependent children as dependents under his or her coverage. In that event, there would be no break in coverage as long as coverage under the Plan is continuous.

Employee Dental Plan


F

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Introduction

The ConocoPhillips Employee Dental Plan (the Plan) provides you and your family with coverage for regular dental checkups, preventive care and other services to keep your teeth and gums healthy.

-
- ✓ Please refer to the Glossary beginning on page O-1 for the definitions of underlined terms used throughout this SPD.

 “Glossary,” page O-1

In this chapter, the term “Company” is used to describe ConocoPhillips and the other companies whose employees are covered by this Plan.

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- ✓ For information on retiree or survivor dental benefits, refer to the separate *Retiree Benefits Handbook* available from the Benefits Center or on hr.conocophillips.com.
-



Who Is Eligible

EMPLOYEES ELIGIBLE FOR THE EXPATRIATE MEDICAL AND DENTAL PLAN

Employees eligible for the Expatriate Medical and Dental Plan **are not** eligible for the Employee Dental Plan.


Employee Eligibility


If you're an active, regular full-time or regular part-time¹ employee, you're eligible to participate in the Plan if you're:

- A U.S. citizen or resident alien employee working within the U.S. (includes rotators) who is paid on the direct U.S. dollar payroll²; or
- A U.S. citizen or resident alien employee working within the U.S. (includes rotators) who is paid on the direct U.S. dollar payroll² and who is on a personal, disability or military leave of absence or on a family medical leave of absence or is an under-age-65 heritage Tosco former employee receiving long-term disability benefits with eligibility designated on Company records.

You're **not** eligible to participate in the Plan if your classification isn't described in this section. For example, temporary employees, intermittent employees, independent contractors, contingent workers, contract workers, leased employees and commission agents aren't eligible for the Plan.


Note: Special rules apply if your spouse/domestic partner is also a Company employee or retiree.

 "If Your Eligible Dependent Is Also a Company Employee or Retiree," at right

 Contact the Benefits Center for questions about whether your collective bargaining agreement expressly provides for your participation in the Plan.

 "Contacts," page A-1

If Your Eligible Dependent Is Also a Company Employee or Retiree

 Review the rules used in determining dependent eligibility under the Plan.

 "Dependent Eligibility," page F-4

If you have an eligible dependent (spouse/domestic partner, dependent child) who is also **employed by ConocoPhillips**, neither you nor any eligible dependent can be covered by more than one Company dental plan. Dual coverage is prohibited even if the other dental plan is union-sponsored dental coverage.

If both you and your spouse/domestic partner are employed by ConocoPhillips, your election is considered to be a separate election from your spouse's/domestic partner's election and cannot be changed during the calendar year unless a change in status occurs (e.g., you get divorced, gain or lose a dependent, change in job status, etc.).

 "Changing Your Coverage," page F-7

If your spouse/domestic partner is a **ConocoPhillips retiree**, he or she can be covered as a dependent under your dental coverage. **Note:** He or she can also have dental coverage through the Retiree Dental Plan; however, coordination of benefits may apply.

 "Coordination of Benefits (COB)," page F-18

¹ Regular part-time employees must be regularly scheduled to work on average at least 20 hours per week.

² Direct U.S. dollar payroll means that payroll check is written in U.S. dollars by a U.S. company participating in the Plan and is not converted to another currency before being paid to the employee.

Dependent Eligibility

- ✓ If an eligible dependent has other dental coverage (in addition to coverage under this Plan), refer to this Plan's coordination of benefits (COB) provisions.

 "Coordination of Benefits (COB)," page F-18

If you enroll in the Plan, your eligible dependents may also be enrolled for coverage. Eligible dependents include your:

- Spouse (including your state-recognized common-law spouse¹; excluding a spouse after a divorce or separation by a legal separation agreement²) or your domestic partner; and
- Child, as follows:
 - Your biological, legally adopted (includes foreign adoptions) or placed for adoption child;
 - Your domestic partner's biological or legally adopted child (includes foreign adoptions), provided the child receives over 50% of his or her support from you and has the same principal place of abode as you for the tax year;
 - Your child under a legal guardianship agreement issued by a court; or
 - Your stepchild, provided the parent is your spouse and you and your spouse either remain married and reside in the same household or your spouse died while married to you.

You can cover the child/stepchild/guardianship child/domestic partner's child if he or she is:

- Under age 26³; or
- Age 26 or older, provided the child was disabled prior to age 26 and coverage is approved by the Plan within 30 calendar days of his or her reaching age 26 or initial eligibility after age 26⁴.

¹ The common-law marriage must be consummated in a state that recognizes common-law marriage, and all state requirements must have been met.

² The Plan will recognize a decree of legal separation or court-approved legal written separation agreement of any kind — including a court-approved separate maintenance agreement.

³ Your child is considered an eligible dependent up to age 26 regardless of student status, marital status, employment status and/or IRS dependent requirements.

⁴ A disabled dependent over age 26 who is disabled prior to age 26 may enroll in the Plan (i) during annual enrollment or (ii) if such disabled dependent experiences a qualified change in status.

Note: A dependent is **not** eligible if he or she:

- Is on active duty in any military service of any country (excluding weekend duty or summer encampments);
- Is not a U.S. citizen, resident alien or resident of Canada or Mexico;
- Is already covered under a Company dental plan as an employee, retiree or as a dependent of either (including COBRA participants and excluding the Retiree Dental Plan);
- Is the child of a domestic partner and has been claimed as a dependent on your domestic partner's or on anybody else's federal tax return for the year of coverage;
- Is the child of a domestic partner and the domestic partnership between you and your domestic partner has ended, even if your domestic partner's child continues to reside with you;
- Is the child of a surrogate mother (is not considered the child of the egg donor) and does not qualify as a dependent otherwise;
- Is no longer your stepchild due to divorce, legal separation or annulment;
- Is a grandchild not legally adopted by you;
- Is placed in your home as a foster child; or
- Is in a relationship with you that violates local law.


Dependent Certification Rules

When you enroll your eligible dependent(s) in the Plan and when you continue their participation at each annual enrollment, you represent the following:

- The individual is eligible under the terms of the Plan; and
- You will provide evidence of eligibility on request.

Enrolling an ineligible dependent **or** not cancelling coverage within 30 calendar days of when an eligible dependent ceases to meet the Plan's dependent eligibility requirements **or** failure to provide required evidence of eligibility is considered by the Plan to be evidence of fraud and intentional misrepresentation of a material fact that will trigger rescission that may be back to the date on which your dependent no longer qualifies as an eligible dependent. If the coverage is rescinded, the Plan will give the participant a 30-calendar-day advance written notice prior to rescission. The Plan has the right to request reimbursement of any claims or expenses paid for an ineligible dependent. If canceling your ineligible dependent's coverage reduces your cost for coverage, any amounts you have overpaid will not be refunded. In addition, you may be subject to disciplinary action — up to and including termination of coverage for benefits in the applicable Plan or termination of employment by the employer for enrolling or keeping an ineligible dependent in the Plan.

Proof documenting dependent eligibility must be provided per rules, which may include requirements for self-certification in addition to documentation, adopted by the Benefits Committee. Failure to provide the certification and/or the requested documents verifying proof of dependent eligibility in a timely manner may cause termination of your dependent's coverage, and you generally will not be able to reinstate coverage until the next annual enrollment period unless you experience a change in status event described in the "Changing Your Coverage" section. If coverage is reinstated you will once again be asked to provide the appropriate documentation of dependent status. Contact the Benefits Center for details or if you have any questions about this requirement.

 "Contacts," page A-1; "Changing Your Coverage," page F-7


How to Enroll, Change or Cancel Coverage

If you want to enroll in dental coverage for yourself or your eligible dependents, you enroll online or call the Benefits Center. Your enrollment materials will contain information to help you make your enrollment elections. If you have questions about the enrollment procedure or need more information, contact the Benefits Center.

 "Contacts," page A-1

When you enroll, you'll:

- Decide which of your eligible dependents you wish to cover, if any; and
- Authorize any required payroll deductions for the cost of the coverage you select.

 Your medical, vision and dental enrollment elections are separate — meaning you can enroll for dental coverage regardless of whether you're enrolled in medical or vision coverage, and vice versa. In the same way, you can choose to enroll different dependents in your dental coverage than in your medical or vision coverage.

Note: The dental Claims Administrator does **not** issue ID cards, but one can be obtained from the Claims Administrator's website.

 "Contacts," page A-1

When to Enroll, Change or Cancel Coverage

You can enroll, change or cancel Plan coverage:

- When you become eligible as a new employee;
- When you become eligible due to a change in your employee classification;
- During annual enrollment; or
- If you have a change in status.

 “Changing Your Coverage,” page F-7

-
- ✓ After your initial eligibility for the Plan, you can enroll only during annual enrollment unless you have a change in status during the year. A disabled dependent over age 26 who is disabled prior to age 26 may enroll in the Plan (i) during annual enrollment or (ii) if such disabled dependent experiences a qualified change in status.
-

When Coverage Begins

The date coverage for you and/or your eligible dependents begins depends on the event and on when you enroll.

For the following event:	If an enrollment action is made with the Benefits Center:	The coverage change effective date is:
Employees newly hired or newly eligible to participate	Within 30 calendar days after the event ¹	The date of the event
Annual enrollment	Within the annual enrollment period	The following Jan. 1
When you have a change in status	See “Changing Your Coverage” on page F-7 for information	See “Changing Your Coverage” for information
When you add a new <u>eligible dependent</u> due to birth, adoption or <u>placement for adoption</u>	Within 90 calendar days after the event ¹	The date of the event
When you return to work as a regular full-time or regular part-time employee on or before the expiration of a <u>leave of absence</u> (if a loss of coverage occurred during the leave)	Within 30 calendar days after the event ¹	The date of the event
When you return to work as a regular full-time or regular part-time employee on or before the expiration of a <u>leave of absence</u> -Labor Dispute (if a loss of coverage occurred during the leave and the leave was 30 calendar days or less)	No enrollment action is required; coverage will be reinstated automatically	The date of the event
When you return to work as a regular full-time or regular part-time employee on or before the expiration of a <u>leave of absence</u> -Labor Dispute (if a loss of coverage occurred during the leave and the leave was more than 30 calendar days)	Within 30 calendar days after the event ¹	The date of the event

¹ If an enrollment action is not made within the allowable number of calendar days after the event, you won't be able to make the enrollment action until the next annual enrollment period (absent another enrollment event), with coverage effective the first of the following calendar year.

-
- ✓ If you're a surviving spouse/domestic partner or eligible child, see “In the Event of Your Death.”

 “In the Event of Your Death,” page F-21

Changing Your Coverage

Because you pay for coverage on a before-tax basis, IRS rules limit when you can make changes to your coverage. Other than during each year's annual enrollment, you can change your coverage election only if you experience a change in status for which you may be required or allowed to make changes to your coverage. The coverage election must be consistent with your change in status, and you cannot make a coverage change for financial reasons or because a provider stops participating in a network.

Because coverage change effective dates vary based on the event and the date of your enrollment action, contact the Benefits Center for further information about when the coverage change will be effective. To make changes, enroll online or call the Benefits Center.

 "Contacts," page A-1

"Change in status" changes may include these life events:

- Your marriage, divorce, legal separation or annulment;
- Death of an eligible dependent;
- Addition of an eligible dependent through birth, adoption, legal guardianship or placement for adoption. (Even if you already have *You + Two or More* coverage, you need to enroll your new eligible dependent(s) in order for their coverage to take effect);
- A relocation or move outside of the U.S. and/or network's coverage area;
- Loss of coverage;
- A Qualified Medical Child Support Order that requires you to provide dental coverage for a child;
- A change in employment status by you or your eligible dependent;
- A change in work schedule by you or your eligible dependent that changes coverage eligibility;
- A change in your eligible dependent's status;
- You and/or your eligible dependents become eligible for and enroll in or lose eligibility for Medicare or Medicaid;
- You and/or your eligible dependents become entitled to COBRA;
- The taking of or return from a leave of absence under the Family Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act of 1994; and

- You or your eligible dependents have a significant change in benefits or costs, such as benefits from another employer, etc.

If you don't report the change to the Benefits Center within 30 calendar days (90 calendar days to add a new eligible dependent due to birth, adoption or placement for adoption) after the event date:

- **You won't be able to change coverage until the next annual enrollment period; and**
- **The change won't be effective until the first of the following calendar year.**

The Benefits Committee shall have the exclusive authority to determine if you're entitled to revoke an existing election as a result of a change in status or a change in the cost or coverage, as applicable, and its determination shall bind all persons.


-
- ✓ If a relocation back to the U.S. or a transfer to the U.S. payroll initiates eligibility for this Plan, you will automatically be enrolled in this Plan unless you elect no coverage.
-

If You Take a Leave of Absence

If you're on a leave of absence, you may continue coverage for yourself and your eligible dependents during the approved leave period — provided you pay any required costs for coverage when they're due.

- During your leave, you pay the same cost for coverage that an active employee would pay.
 - If you're on a paid leave, your cost for coverage will continue to be deducted from your paycheck on a before-tax basis.
 - If you're not receiving a paycheck from the Company, you'll pay the cost for coverage to ConocoPhillips on an after-tax basis. (ConocoPhillips will bill you for the cost for coverage.)
- When you return to work, the Company will resume deducting the cost for coverage from your paycheck on a before-tax basis.

If you end your coverage while you're away on leave — or if your coverage is ended due to non-payment of required costs for coverage — you must meet the same criteria as an active employee if you want to re-enroll in the Plan upon your return to work.

 “Who Is Eligible,” page F-3; “How to Enroll, Change or Cancel Coverage,” page F-5

✓ If You're on a Military Leave of Absence

See “USERRA Continuation Coverage” for general information regarding your dental coverage while you're on a military leave of absence.

 “USERRA Continuation Coverage,” page N-20

If You Have a Leave of Absence-Labor Dispute

If you're placed on a leave of absence-Labor Dispute, coverage for you and your eligible dependents will end on the last day of the month in which the leave begins. You may continue coverage for yourself and your eligible dependents during the leave under COBRA provisions. If you're eligible for retiree dental insurance, you may elect that coverage. See the chart on page F-6 for coverage after you return to work. If you are on a leave of absence-Labor Dispute during a regularly scheduled annual enrollment, you won't be eligible and a special annual enrollment period will be provided after you return from the leave of absence-Labor Dispute.

What the Plan Costs

You and the Company share in the cost of dental coverage. Your cost for coverage for yourself and your eligible dependents is based on the level of coverage you elect, regardless of your scheduled workweek hours (regular full-time or regular part-time). Cost sharing is designated with Plan eligibility on Company records for under-age-65 heritage Tosco former employees receiving long-term disability benefits.

Your cost for coverage is automatically deducted from your paycheck on a before-tax basis, which means that your taxable pay is lower — and so is the amount you pay for Social Security and Medicare taxes, federal income tax and, in most areas, state and local income tax. Your enrollment authorizes the deductions to be taken from your paycheck on a before-tax basis.


The Benefits Committee reserves the right to recover any underpayments by the employee or eligible dependent, made through error or otherwise, by offsetting future payments, invoicing the affected participant or by other means as the Benefits Committee deems appropriate.

When you enroll, you'll receive information about how to access the current costs.

✓ **The Benefits Committee has authority to make temporary changes in Plan provisions as appropriate, at the Benefits Committee's discretion, to respond to a natural or man-made emergency or disaster so participants can obtain covered services and benefits. In any such instance, the Benefits Committee shall adopt administrative procedures specifying the changes and the duration of such changes.**

Employee Dental Benefit Highlights


The benefits provided are discussed in the chart below. **Note:** Limitations apply to some Plan benefits. See “Covered Expenses” and “Non-Covered Expenses” for information.


 “Covered Expenses,” page F-14; “Non-Covered Expenses,” page F-16


Plan Provision	CP Dental Benefit		
	Network*	Non-Network	Out-of-Area** Dental Benefit
Annual deductible	\$50 individual; \$150 family maximum	\$100 individual; \$300 family maximum	\$50 individual; \$150 family maximum
Annual maximum benefit	\$2,000 per person ¹	\$2,000 per person ¹	\$2,000 per person
Diagnostic and Preventive Services ²	What You Pay	What You Pay ³	What You Pay ³
Oral Exams	100% covered	100% covered ⁴	100% covered
Bitewing/Full Mouth X-Rays	100% covered	100% covered ⁴	100% covered
Cleaning and Scaling	100% covered	100% covered ⁴	100% covered
Prophylaxis Treatments	100% covered	100% covered ⁴	100% covered
Fluoride Treatments	100% covered	100% covered ⁴	100% covered
Space Maintainers (for missing primary teeth)	100% covered	100% covered ⁴	100% covered
Sealants	100% covered	100% covered ⁴	100% covered
Basic Services ²	What You Pay	What You Pay ³	What You Pay ³
Fillings (amalgam, composite, synthetic porcelain and plastic restorations)	20% after deductible	40% after deductible	20% after deductible
Endodontic treatment	20% after deductible	40% after deductible	20% after deductible
Periodontic treatment	20% after deductible	40% after deductible	20% after deductible
Re-linings and re-basings of existing removable dentures	20% after deductible	40% after deductible	20% after deductible
Repair or re-cementing of existing crowns, inlays, onlays, dentures or bridgework	20% after deductible	40% after deductible	20% after deductible
Oral surgery (extractions, root, periodontal and related surgical procedures)	20% after deductible	40% after deductible	20% after deductible

See footnotes on page F-11.

(continued)

 If you’re enrolled in the Expatriate Medical and Dental Plan, please refer to the materials provided by the [Claims Administrator](#) for information about your coverage.


 The list of Plan benefits in this chart should address most services and treatments. Limitations and exclusions may apply to some services. However, if you have additional questions about a specific treatment or to obtain a predetermination of the benefits that will be paid by the Plan, you should call the [Claims Administrator](#).

 “Contacts,” page A-1; “Predetermination of Benefits,” page F-13

Plan Provision	CP Dental Benefit		
	Network*	Non-Network	Out-of-Area** Dental Benefit
Major Services²	What You Pay	What You Pay³	What You Pay³
Crowns, inlays, onlays, jackets and cast restoration benefits	50% after deductible	50% after deductible	50% after deductible
Implant services (<i>repair, maintenance and removal</i>)	50% after deductible	50% after deductible	50% after deductible
Oral surgery (<i>implant surgeries</i>)	50% after deductible	50% after deductible	50% after deductible
Orthodontia Services²	What You Pay	What You Pay³	What You Pay³
Orthodontia for you and your <u>eligible dependents</u>	50%	50%	50%
Lifetime maximum orthodontia benefit ⁵	\$2,000/per person	\$2,000/per person	\$2,000/per person


* A network deficiency may be granted if the participant does not have at least two **specialty network providers** within a 30-mile radius of their home ZIP code. Contact the Claims Administrator to obtain a network deficiency.

** The Out-of-Area dental benefit is available only to those without access to at least two network providers within a 10-mile radius of their home ZIP code. The Out-of-Area ZIP codes will be updated on Jan. 1 of each year. Contact the Claims Administrator for questions or further information.


 "Contacts," page A-1

¹ Network and non-network charges combined.

² See "Covered Expenses" for explanations of services and any limitations on coverage.


 "Covered Expenses," page F-14

³ The Plan doesn't cover charges in excess of the reasonable and customary fee. See the Glossary for more information on reasonable and customary charges.

 "Glossary," page O-19

⁴ Non-network charges are reimbursed similar to network charges in the geographic area. Your provider may bill you for the difference between the approved network charge and the billed amount.

⁵ This maximum is separate from the Plan's annual maximum benefit.


 For participants who change coverage between the Expatriate Medical and Dental Plan and the Employee Dental Plan, claims paid will **not** be exchanged and applied to the other coverage's annual deductible, annual maximum benefit or any lifetime maximum orthodontia benefit.

How the Employee Dental Plan Works

The Plan is a Preferred Provider Organization (PPO) and uses the MetLife Preferred Dentist Program (PDP) Plus Network. You have a choice when accessing your dental care. You can go to:

- Any participating network provider who has agreed to charge participants a contracted MetLife Preferred Dentist Program (PDP) fee, which is usually lower than those charged by non-network providers and is not subject to reasonable and customary provisions, and to file the dental claims for you. You will receive the “network” benefit provisions in the chart on the previous two pages; or
- A non-network provider. Services received from non-network providers **are** subject to reasonable and customary provisions. You may choose to request a pre-determination of benefits to see how much the dental benefit will pay for the proposed services.

The Plan covers a wide range of medically necessary dental services regardless of whether you use a network provider or a non-network provider.

 “Employee Dental Benefit Highlights,” page F-10;
“Covered Expenses,” page F-14

To Find a Network Provider

- Ask your provider if he or she is in the MetLife Preferred Dentist Program (PDP) Plus network.
- Access the Claims Administrator’s website for network information, or call the Claims Administrator and get the information over the phone.

 “Contacts,” page A-1

It’s your responsibility to ensure that you use MetLife PDP Plus network providers if you want to receive the benefit of lower, contracted rates.

Because network providers may change over time, it is recommended that you confirm that your provider is still in the MetLife PDP Plus Network each time an appointment is made.

Some Basic Terms

Annual Deductible

- ✓ In order to encourage preventive care, the annual deductible is waived for covered preventive and diagnostic services, up to Plan limits. It’s also waived for orthodontic services, up to Plan limits.

 “Employee Dental Benefit Highlights,” page F-10

The annual deductible is the initial amount you pay for covered dental services you receive each calendar year before the Plan begins paying benefits.

- **If you have You Only coverage:** You must meet the annual individual deductible before most benefit payments begin.
- **If you have You + One coverage:** Each covered individual must meet the annual individual deductible before most benefit payments for that individual begin.
- **If you have You + Two or More coverage:** Generally, each covered individual must meet the annual individual deductible before most benefit payments for that individual begin. However, once the annual family deductible has been met, all covered family members are considered to have met their individual deductible for the calendar year. The annual family deductible can be met by any combination of family members. However, no one individual can contribute more than his or her individual deductible amount toward the annual family deductible.

For example: For a family of four, the \$150 annual family deductible for network services could be met by each family member incurring \$37.50 in covered expenses ($4 \times \$37.50 = \150) or by three family members each incurring \$50 in covered network services ($3 \times \$50 = \150). It could **not** be met by one family member incurring \$150 in covered expenses, because only the first \$50 of those expenses would apply toward the family maximum.

Eligible expenses applied to the network annual deductible are also applied to the non-network annual deductible (and vice versa) regardless of whether they were incurred with network or non-network providers.

The following expenses don't apply to the annual deductible:

- Diagnostic and preventive services;
- Expenses not covered by the Plan;
- Expenses in excess of reasonable and customary limits; or
- Orthodontic services.

Coinsurance

"Coinsurance" is the percentage of covered expenses you pay for dental services once you satisfy any required annual deductibles. You are responsible for any expenses in excess of reasonable and customary limits (not applicable to network provider reimbursement level).

 "Employee Dental Benefit Highlights," page F-10

Annual Maximum Benefit

The annual maximum benefit is the maximum amount the Plan will pay each calendar year for each covered person's covered dental services. Expenses in excess of reasonable and customary limits and for orthodontic services do not apply to the annual maximum benefit. This amount is separate from the lifetime maximum benefit for orthodontia described below.

Lifetime Maximum Benefit for Orthodontia

A lifetime maximum benefit applies for each covered person's covered orthodontia treatment. The lifetime maximum is separate from the annual maximum benefit described above.

Alternate Benefit

If the Claims Administrator determines that a service, less costly than the covered service the dentist performed, could have been performed to treat a dental condition, benefits paid will be based upon the less costly service if such service:

- Would produce a professionally acceptable result under generally accepted dental standards; and
- Would qualify as a covered service.

Examples for when both methods are professionally acceptable and the less costly service will be used to determine the Plan benefit include:

- A filling instead of an inlay for treating tooth decay or breakdown;
- A filling instead of a crown for treating tooth decay or breakdown; and
- A partial denture instead of fixed bridgework for replacing multiple missing teeth in an arch.

Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this Plan, these separate steps of one service are considered to be part of the more comprehensive service. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. When the benefit paid is based on the less costly service, the dentist may charge you or your covered dependent for the difference between the service that was performed and the less costly service, even if the service is performed by a network provider.

Important Plan Features

Predetermination of Benefits

A voluntary predetermination of benefits is available to let you know in advance whether a service is medically necessary and how much it will cost. You decide whether you want to obtain a predetermination of benefits — there is no reduction in benefits if a predetermination isn't obtained. However, obtaining a predetermination can help ensure the appropriateness of the proposed treatment and may be able to reveal other options. It can help you determine what the Plan will pay and what will be your responsibility to pay.

Call the [Claims Administrator](#) and request a predetermination of benefits form if you want to:

 [“Contacts,” page A-1](#)

- See if a proposed treatment is covered by the Plan;
- Receive an estimate of what you’ll pay for the proposed treatment; and
- See the estimated costs for the treatment, including the non-network reimbursement level, if applicable.

✓ **Note:** A predetermination of benefits should be used as a guide when considering treatment options and not as a guarantee of benefit payment.

If You’re Outside the United States


If you require dental services while traveling outside the United States on pleasure or business, you can get a referral in over 200 countries to a local dentist for immediate care under the International Dental Travel Assistance program. The local dentist you’re referred to will have Western dental training, local accreditation, appropriate technology and will usually be English-language proficient. The cost will be covered as a non-network expense according to the rules of the Plan. In order to be covered, the services from any provider outside the U.S. must have been received from a licensed dentist. You should:

- Pay for the services received;
- If possible, have the bill translated into English; and then
- Submit a claim form, in the currency of the country in which the licensed dentist is located, to the [Claims Administrator](#) for reimbursement.

 [“Contacts,” page A-1](#)

Covered Expenses

The Plan covers most medically necessary preventive, basic, and major dental and orthodontic procedures. Covered services are subject to the annual deductible, coinsurance (e.g., your share of the cost), annual benefit maximum, lifetime maximum, exclusions and limitations (including reasonable and customary limitations).

 [“Employee Dental Benefit Highlights,” page F-10;](#)
[“Annual Deductible,” page F-12;](#) [“Non-Covered Expenses,” page F-16](#)

More information on covered expenses is shown at right. The following list of covered expenses, although comprehensive, may not be all inclusive. Other specific expenses may be determined to be covered consistent with other terms of the Plan.

Preventive and Diagnostic Services

✓ In order to encourage preventive care, the annual deductible is waived for covered preventive and diagnostic services, up to Plan limits.

 [“Employee Dental Benefit Highlights,” page F-10](#)

Preventive and diagnostic services include the following procedures that help your dentist evaluate your dental health and prevent the deterioration of teeth and gums:

- Oral exams — including preventive cleanings, non-periodontal scaling of teeth and bitewing X-rays at the time of the oral exam (may or may not be part of a routine cleaning) — up to the following limits:
 - Exams and cleaning — three per calendar year, regardless of time between each visit; and
 - Bitewing X-rays¹ — two per calendar year, regardless of time between each visit, for covered children under age 19 and once every calendar year for adults;
- Full-mouth X-rays¹ — limited to one set every 60 months;
- Periapical X-rays¹ (images of the entire tooth from crown to root tip) and other medically necessary X-rays¹;
- Prophylaxis treatment for three exams per calendar year, regardless of time between each treatment;
- Topical fluoride treatment for covered children under age 14 — limited to one treatment per calendar year;
- Space maintainers for covered children under age 14 to prevent teeth from drifting after the loss of primary teeth — limited to once per lifetime per area;
- Sealants for covered children under age 19 — limited to one application of sealant material every 60 months for each non-restored, non-decayed 1st and 2nd molar; and
- Emergency treatment for dental pain — limited to minor procedures.

¹ Benefit for multiple X-rays performed on same date of service will be based on most comprehensive type of X-ray and its provisions. Contact the [Claims Administrator](#) if there is a medical reason for multiple X-rays to be considered separately. If covered separately, the Plan will cover the cost of the X-ray or the cost of full-mouth X-rays, whichever is less.

Basic Restoration Services

Basic restoration services include the following procedures necessary to restore the teeth:

- Simple extractions;
- Fillings — amalgam, synthetic porcelain, plastic and resin composites;
- Prefabricated stainless steel or resin crowns — limited to once per tooth every 60 months;
- Crown, denture and bridgework repair;
- Adjustment of dentures — no earlier than six months after installation;
- Relining/rebasing of existing removable dentures — no earlier than six months after installation and limited to once every 36 months;
- Tissue conditioning — limited to once every 36 months;
- Pin retention in addition to restoration — limited to once per tooth every 60 months;
- Occlusal adjustment — limited to once every 12 months for complete adjustment;
- Oral surgery — surgical removal of visible and impacted teeth; root and periodontal surgery;
- Periodontics — non-surgical treatment of diseases of the gums and tissues of the mouth — up to the following limits:
 - Periodontal scaling and root planning — once per quadrant every 24 months; and
 - Periodontal maintenance — four times per year, combined with cleanings;
- Endodontics:
 - Treatment of dental pulp — final restorations limited to once per tooth per 24 months;
 - Root canal therapy — limited to once per tooth every 24 months;
- Consultations (diagnostic service provided by a dentist or physician other than practitioner providing the treatment) — limited to once per 12 months; and
- General anesthesia when medically necessary in connection with covered dental services — limited to a maximum of two hours.

Major Restoration Services

Major restoration services include the following restoration and prosthodontic procedures:

- Initial installation of crowns, inlays or onlays to restore diseased teeth — limited to once every 60 months;
- Replacement of an existing crown, inlay or onlay — provided it's more than 60 months old and cannot be made serviceable;
- Initial installation of full or partial dentures and fixed bridgework to replace natural teeth or implants, provided the teeth were lost while you were covered under a ConocoPhillips dental plan;
- Replacement of an existing temporary full denture — provided it can't be made serviceable and the permanent denture is installed within 12 months after the temporary denture was installed;
- Replacement of an existing denture or bridge — provided it's more than 60 months old and cannot be made serviceable;
- Implant services (supported connecting bar) — limited to once every 60 months;
- Implant repair and maintenance — limited to once every 12 months;
- Implant/abutment supported removable denture, limited to:
 - Once every 12 months on immediate — immediate dentures have to be replaced by a permanent denture within 12 months or it becomes the permanent denture and is then subject to the standard 60-month replacement limitation — an immediate denture cannot be done every 12 months;
 - Once every 60 months for complete replacement; and
- Oral surgery — including implant surgery.

Orthodontia Treatment

- ✓ The annual deductible is waived for orthodontic services, up to Plan limits.


 “Employee Dental Benefit Highlights,” page F-10

Orthodontia treatment for children and adults includes:

- Diagnostic procedures, including oral exams and X-rays; and
- Treatment, including appliances (for example, braces and retainers).

Your orthodontist should file a claim with the Claims Administrator detailing the full treatment plan (e.g., “banding” date, total fees and planned length of treatment):


- Benefits are payable at 50% of the covered expenses.
- 20% of the total charge is considered for payment to the provider at the time the appliance is placed.
- The balance of the total charge is prorated over the estimated months of treatment.
- Benefits for the months of treatment will be paid automatically, provided:
 - The patient is still eligible for coverage;
 - Active treatment is still being rendered; and
 - The lifetime maximum benefit for orthodontia treatment has not been paid.

 “Lifetime Maximum Benefit for Orthodontia,” page F-13

Non-Covered Expenses

While the Plan provides benefits for many dental services and supplies, some are not covered. These exclusions include, **but are not limited to**:

- Charges for oral hygiene instruction;
- Dietary or nutritional counseling;
- Oral/facial images (including intra- and extra-oral images);
- Caries susceptibility tests;
- Tobacco counseling for the control of oral disease;
- Canal preparation and fitting of pre-formed dowels or posts;
- Unspecified maxillofacial prostheses;
- Provisional pontics or retainer crowns;
- Occlusal orthotic devices;
- Appliance removal by other than the dentist who placed appliance, including removal of archbars;
- Orthodontic treatment that’s not billed as part of the contract fee;
- Replacement of lost or broken retainers;
- Fixed and removable appliances for correction of harmful habits;
- Initial installation of implants, implant crowns, denture, partial and bridges to replace one or more teeth which were missing before the affected person was covered by this Plan, except for congenitally missing teeth;
- Non-intravenous conscious sedation;
- Behavior management;
- Fabrication of athletic mouthguards;
- Enamel microabrasion;
- Odontoplasty, one or two teeth — including removal of enamel projections;
- Dental treatment due to an accidental injury or diseases (such as jaw tumors or oral cancer) to teeth or the jaw (may be covered instead by a medical option under the Employee Medical Plan);

 “Surgery, Therapy, Medical and Physician Services,” page B-33

- Diagnosis and treatment of temporomandibular joint dysfunction (TMJ);
- Prescription drugs;
- Restoration of a tooth for reason of attrition or discoloration (rather than for decay or injury);
- Services and supplies that are partially or wholly cosmetic in nature, including teeth whitening;
- Dentist's charges for education and training;
- Services and supplies covered by any Workers' Compensation law;
- Treatment of conditions resulting from acts of war;
- Services and supplies provided or required under a government law (except for Medicaid or a plan for a government's own employees);
- Services and supplies provided or required in connection with past or present service in the armed forces of a government;
- Services and supplies that are not medically necessary for treatment;
- Services and supplies not prescribed, recommended and approved by your or your covered dependent's attending physician or dentist;
- Services provided by a physician or dentist in residency or internship, or charges made by a "denturist" or free-standing denture lab service;
- Treatment other than by a physician, dentist or dental hygienist — except when performed by a duly qualified technician under the direction of a dentist or physician;
- Services and supplies that the Claims Administrator determines to be investigational or experimental;
- Charges you're not legally obligated to pay;
- Services that are otherwise free to you; or
- Missed appointments.

The above list of non-covered expenses isn't all inclusive. Other specific expenses may be determined not to be covered consistent with other terms of the Plan.

How to File a Claim

-
- ✓ You don't need to file a claim if you go to a network provider for a covered expense. Your network provider will submit your claim to the Claims Administrator on your behalf.
-

If you're enrolled in the Plan and go to a non-network provider, you may have to pay for dental care services at the time you receive them and then file a claim for reimbursement. To do so, you'll need to submit the following to the Claims Administrator:

- A completed claim form; and
- All itemized bills, indicating the date of service, description of service provided, diagnosis, name of the provider and charges incurred.

You can request claim forms from the Claims Administrator. **Note:** See "If You're Outside the United States" for information on filing a claim for services received outside the U.S.


 "If You're Outside the United States," page F-14

-
- ✓ Send your completed claims and supporting documentation to the Claims Administrator at the address shown under "Contacts."

 "Contacts," page A-1

-
- ✓ **Dental claims must be received no later than Dec. 31 of the year following the date service was rendered.** For example, a claim dated March 2025 must be received no later than Dec. 31, 2026. Claims received after the Dec. 31 deadline are not eligible for payment under the Plan.
-

Slightly different procedures apply if you're making a pre-service claim or urgent care claim. For those claims, call the appropriate Claims Administrator. The Claims Administrator will assist you with your request for preapproval. The claim will be considered filed on the date you call the Claims Administrator.

 *"Medical, Vision, Dental, FSP, Employee Assistance Plan, Houston Onsite Medical Clinic Plan and The Well Onsite Medical Clinic Plan Claims," page N-32*

Claim Review and Appeal Procedure

For information about when to expect a response to your claim from the Claims Administrator and/or Appeals Administrator or how to file an appeal if your claim is denied, refer to the "Claims and Appeals Procedures" section.

 *"Claims and Appeals Procedures," page N-26*


Coordination of Benefits (COB)

If you or a covered dependent have other group health coverage — for instance, if your children are covered under your Employee Dental Plan and under your spouse's employer-provided dental plan — coordination of benefits (COB) is used to determine the portion of the expense paid by each plan. The Plan coordinates benefits with other group plans covering you and your dependents.

When benefits are coordinated, certain rules are applied to determine which plan is considered the "primary plan" and which is considered the "secondary plan."



✓ Coordination of Benefits is a cooperative claim payment between two or more insurance carriers that applies when a member is covered under more than one group plan. The Employee Dental Plan uses the non-duplication of benefits (non-dup) method for coordination of benefits. This type of Coordination of Benefits may not result in 100% reimbursement of the incurred expenses. The non-dup method pays the difference between what the primary carrier paid and what the secondary benefit would have paid had there been no other coverage. If the primary carrier pays the same as or more than the secondary benefit plan would, there is no additional benefit paid by the secondary carrier. However, if the primary plan pays a lesser amount than the secondary plan, then the secondary plan would reduce its payment by the amount paid by the primary plan and pay only the difference. You're required to tell the Claims Administrator if you or your dependents have other coverage upon submission of your or your dependent's dental claim.

If an individual is covered under two or more plans, the order in which benefits shall be paid is as follows:

- A plan that doesn't have a coordination of benefits provision is the primary plan and determines its benefits first.
- The plan that covers the individual as an employee is primary; the plan covering the individual as a dependent is secondary.
- If you're covered by this Plan and your spouse/domestic partner is covered under another plan, special rules apply to dependent children covered under both plans:
 - In the case of domestic partnerships, the plan of the natural parent is primary.
 - In the case of married parents who aren't divorced or separated, the plan of the parent whose birthday (the month and day, not the year) falls earlier in the calendar year is primary. If both parents have the same birthday, the plan that has covered a parent longer is primary.
- When parents are separated or divorced, or terminating their domestic partnership and living apart, and the dependent children are covered by more than one plan, the following rules apply if there isn't a court order to the contrary:
 - The plan of the parent with custody of (or court ordered financial responsibility for) the dependent child is primary.
 - The plan of (1) the spouse of the parent with custody of the dependent child or (2) the domestic partner of the natural parent with custody of the dependent child is secondary.
 - The plan of the parent or domestic partner without custody (or court ordered financial responsibility) pays last.
- If you have COBRA continuation coverage, the COBRA coverage will be secondary to a plan that covers you as an employee (or as an employee's dependent).
 *"COBRA Continuation Coverage," page N-12*
- The plan covering an individual as an employee (or as an employee's dependent) who is neither laid-off or retired is primary. The plan covering the individual as a laid-off or retired employee (or that individual's dependent) is secondary.
- If none of the above rules apply, the plan that has covered the individual longer is primary, and the plan that has covered the individual for less time is secondary.

When Coverage Ends


✓ If you become ineligible for coverage under the Plan, you may be eligible to continue coverage as follows:

- Through COBRA continuation coverage;
 *"COBRA Continuation Coverage," page N-12*
- Through retiree coverage.
 *Refer to the separate **Retiree Benefits Handbook** available from the Benefits Center or on hr.conocophillips.com*

In the event of your death, your surviving spouse/domestic partner and eligible dependent children may be eligible to continue dental coverage through the Retiree Dental Plan.

 *"In the Event of Your Death," page F-21*

Your coverage will end on the earliest of the following events:

- The last day of the month in which your employment ends for any reason (excludes heritage Tosco former employees receiving long-term disability benefits with Plan eligibility designated on Company records whose coverage ends the earliest of either a) the last day of the month prior to Medicare eligibility due to reaching age 65; or b) the last day of the month in which long-term disability benefits terminate);
- The last day of the month in which you no longer meet the Plan's eligibility requirements;
 *"Employee Eligibility," page F-3*
- The last day of the month in which your coverage is terminated for any other reason not stated in this section;
- The last day of the month in which you don't pay the required cost for coverage;
- The last day of the month in which your leave of absence-Labor Dispute begins;
- If you have continued coverage during a leave of absence and you don't return to work as an employee at the end of the leave, on the last day of the month in which the earliest of the following events occurs:
 - The leave expires; or
 - You first notify the Company that you don't intend to return to work;

- The date of your death (see “In the Event of Your Death” for information about continued dental coverage for your surviving dependents); or

 “In the Event of Your Death,” page F-21

- The date on which the ConocoPhillips Employee Dental Plan is terminated.

Note: If coverage is terminated or lowered during the month, no reimbursements for any difference in dental coverage level are made for the month.

Benefits will be extended for certain treatment in progress after dental coverage under the Plan otherwise ends if:

- A tooth was prepared for crowns, bridges, inlays or onlays, the final impression was taken while you or your dependents were covered under the Plan, and the service or supply was furnished within 90 days after your coverage ended;
- The final impression for full or partial dentures was taken while you or your dependents were covered under the Plan, and the service or supply was furnished within 90 days after your coverage ended; or
- A tooth was opened into the pulp chamber for root canal therapy while you or your dependents were covered under the Plan, and the service or supply was furnished within 90 days after your coverage ended.

Coverage for your covered dependent(s) ends on the earliest of the following events:

- The last day of the month in which your coverage ends for any reason;
- The date on which your dependent no longer qualifies as an eligible dependent as defined by the Plan.
Exception: A coverage loss due to a child dependent’s age or divorce/legal separation/annulment from spouse/dissolution of domestic partnership will occur the last day of the month in which the event occurred;
- The last day of the month in which coverage for your dependent(s) is terminated for any other reason not stated in this section;
- The last day of the month in which you don’t pay the required cost for dependent coverage;
- The date on which your dependent becomes eligible for coverage as a Company employee; or
- The date of your dependent’s death.

In the Event of Your Death

This section does **not** apply to the children of a domestic partner.

A surviving dependent who doesn't qualify for the survivor coverage — or who does qualify, but chooses not to enroll in that coverage — may be eligible to continue coverage through COBRA.

 “COBRA Continuation Coverage,” page N-12

If you were an active employee, were on a leave of absence or were an under-age-65 heritage Tosco former employee receiving long-term disability benefits with eligibility designated on Company records at the time of your death, dental coverage for your surviving spouse/domestic partner and eligible dependent children who were enrolled as dependents under your coverage at the time of your death will continue until the last day of the month in which your death occurred. At that point, your dependents may be eligible to continue coverage through COBRA or through the ConocoPhillips Retiree Dental Plan.

 “COBRA Continuation Coverage,” page N-12

If your surviving spouse and eligible dependent children **weren't** covered under the Plan on the date of your death, they'll be notified if they are eligible for the Retiree Dental Plan and given the opportunity to enroll (surviving domestic partners will not be eligible to enroll if not covered on the date of your death). If eligible for coverage, the children (excluding children of the domestic partner) can enroll in the Retiree Dental Plan regardless of whether your surviving spouse also enrolls.

Coverage for your surviving spouse/domestic partner and eligible children under the Retiree Dental Plan can be the same coverage that you would have been eligible for as a retiree or long-term disability participant. Any expenses that had been applied to your surviving spouse's/domestic partner's and eligible children's annual deductible, annual maximum benefit or lifetime maximum benefit do **not** carry over to their new Plan coverage.

-
- ✓ For retiree dental eligibility provisions, coverage provisions and costs, refer to the separate *Retiree Benefits Handbook* available from the Benefits Center or on hr.conocophillips.com.
-

-
- ✓ If your surviving spouse/domestic partner is eligible for coverage under a ConocoPhillips plan as an active employee, upon your death, he or she can choose to enroll in one of those plans as an employee rather than as a surviving spouse/domestic partner.
-

 “Who Is Eligible,” page F-3

Your surviving spouse/domestic partner could then choose to cover his or her eligible dependent children as dependents under his or her coverage. In that event, there would be no break in coverage as long as coverage under the Plan is continuous.

Flexible Spending Plan

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✓ Please refer to the Glossary beginning on page O-1 for the definitions of underlined terms used throughout this SPD.

📖 “Glossary,” page O-1

In this chapter, the term “Company” refers to ConocoPhillips and the other companies that have adopted this Plan.

✓ Because of the tax advantages, tax law is very strict about how you use your HCFSA and DCFSA. Before participating in these accounts, be sure to read “IRS Regulations/ Limitations.”

📖 “IRS Regulations/ Limitations,” page G-16

Introduction

The ConocoPhillips Flexible Spending Plan (the Plan) provides you with a convenient way to lower your taxes by letting you set aside money — on a before-tax basis — to pay for certain eligible expenses. The Plan has four features:

- **The Flexible Spending Premium Account (FSPA)** — which allows you to pay your ConocoPhillips Employee Medical Plan, ConocoPhillips Employee Vision Plan, ConocoPhillips Employee Dental Plan or ConocoPhillips Expatriate Medical and Dental Plan (with exclusions¹) costs with before-tax contributions.
- **Health Care Flexible Spending Account (HCFSA) with two options** — which allow you to use your before-tax contributions to reimburse yourself for your and your eligible dependents¹ eligible health care expenses that aren’t covered by your health care coverage:
 - **The Limited Purpose HCFSA** (if you enroll in the HDHP or the HDHP Base medical option with a Health Savings Account (HSA)).
📖 “The HDHP and HDHP Base Options and Health Savings Accounts (HSAs),” page B-19
 - **The General HCFSA** (if you’re not enrolled in the HDHP or HDHP Base option with an HSA).
- **The Dependent Care Flexible Spending Account (DCFSA)** — which allows you to use your before-tax contributions to reimburse yourself for eligible dependent care expenses so that you (and your spouse, if you’re married) can work.
- **Employee Health Savings Account (HSA) Contributions** — which allows you to make before-tax contributions to your Bank of America (BoFA) HSA. See page B-19 of the Employee Medical Plan chapter of this handbook for further information on HSA contributions.

📖 “The HDHP and HDHP Base Options and Health Savings Accounts (HSAs),” page B-19

Your FSPA contributions and any amounts you choose to contribute to an HCFSA, HSA or DCFSA are contributed through automatic before-tax payroll deductions. Because your contributions are made **before** payroll taxes are calculated and deducted, you don’t pay Social Security or Medicare taxes, federal income tax and, in most areas, state or local income taxes on them.

¹ An employee who is not a U.S. citizen or resident alien or who wants to cover dependents who are not U.S. citizens, resident aliens, residents of Canada or residents of Mexico is excluded.

Who Is Eligible

If you're an **active, regular full-time or regular part-time¹ employee**, you're eligible to participate in the Flexible Spending Plan if you're:

- A U.S. citizen or resident alien employee working within or outside the U.S. (includes rotators and U.S. expats) who is paid on the direct U.S. dollar payroll²; or
- A U.S. citizen or resident alien employee working within or outside the U.S. (includes rotators and U.S. expats) who is paid on the direct U.S. dollar payroll² and who is on a personal, disability or military leave of absence or on a family medical leave of absence.

You're **not** eligible to participate in the Plan if your classification isn't described in this section. For example, temporary employees, intermittent employees, independent contractors, contingent workers, contract workers, leased employees and commission agents aren't eligible for the Plan.

¹ Regular part-time employees must be regularly scheduled to work on average at least 20 hours per week.

² Direct U.S. dollar payroll means that payroll check is written in U.S. dollars by a U.S. company participating in the Plan and is not converted to another currency before being paid to the employee.


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- ✓ Contact the Benefits Center for questions about whether your collective bargaining agreement expressly provides for your participation in the Plan.

 "Contacts," page A-1

How to Enroll, Change or Cancel Contributions

-
- ✓ You don't need to enroll in an FSPA. Coverage under that account allows your contributions for medical, vision and dental coverage to be paid with before-tax contributions and begins automatically if you enroll in medical, vision or dental coverage under the ConocoPhillips Employee Medical Plan, ConocoPhillips Employee Vision Plan, ConocoPhillips Employee Dental Plan or ConocoPhillips Expatriate Medical and Dental Plan (with exclusions¹) or if you change your medical, vision or dental enrollment elections.
-

If you want to contribute to an HCFSA or DCFSA you **must enroll each plan year** by the deadlines shown under "When to Enroll, Change or Cancel Elections." You enroll online or call the Benefits Center. Your enrollment materials will contain information to help you make your enrollment elections. If you have questions about the enrollment procedure or need more information, contact the Benefits Center.

 "When to Enroll, Change or Cancel Elections," page G-4; "Contacts," page A-1

When you enroll, you'll:

- Choose the amount you want to contribute to the HCFSA and/or DCFSA (that amount is deducted in equal installments from your pay on a before-tax basis); and
- Authorize any required payroll deduction contributions for the coverage you select.

¹ An employee who is not a U.S. citizen or resident alien or who wants to cover dependents who are not U.S. citizens, resident aliens, residents of Canada or residents of Mexico is excluded.


HIPAA SPECIAL ENROLLMENT

(Applies only to enrollment in medical coverage and premium payment under the FSPA for that coverage)

If you are declining enrollment for yourself or your eligible dependents (including your spouse/domestic partner) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and your eligible dependents in the Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage and you can no longer afford the coverage).

In addition, if you have previously declined coverage and gain a new eligible dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents.

To request special enrollment or obtain more information, contact the Benefits Center.

 "Contacts," page A-1

When to Enroll, Change or Cancel Elections

You can elect to enroll, change or cancel contributions to an HCFSA or DCFSA:

- When you become eligible as a new employee (unless you are hired in the last month of the calendar year);
- When you become eligible due to a change in your employee classification;
- During annual enrollment; or
- If you have a change in status.

 "Changing Your Coverage," page G-6

-
- ✓ Your enrollment in an HCFSA or DCFSA does NOT carry forward to the next calendar year — even if your initial enrollment was in the last quarter of the year. You need to re-enroll during annual enrollment each year if you want to participate for the next year.
-

When Coverage Begins

The date coverage begins depends on the event and on when you enroll.

For the following event:	If an enrollment action is made with the Benefits Center:	The coverage change effective date is ¹ :
Employees newly hired or newly eligible to participate	Within 30 calendar days after the event ²	The date of the event
Annual enrollment	Within the annual enrollment period	The following Jan. 1
When you have a change in status	See “Changing Your Coverage” on page G-6 for information	See “Changing Your Coverage” for information
When you add a new <u>eligible dependent</u> due to birth, adoption or <u>placement for adoption</u>	Within 90 calendar days after the event ²	The date of the event
When you return to work as a regular full-time or regular part-time employee on or before the expiration of a <u>leave of absence</u> (if a loss of coverage occurred during the leave)	Within 30 calendar days after the event ²	The date of the event
When you return to work as a regular full-time or regular part-time employee on or before the expiration of a <u>leave of absence</u> -Labor Dispute (if a loss of coverage occurred during the leave and the leave was 30 calendar days or less)	No enrollment action is required; coverage will be reinstated automatically	The date of the event
When you return to work as a regular full-time or regular part-time employee on or before the expiration of a <u>leave of absence</u> -Labor Dispute (if a loss of coverage occurred during the leave and the leave was more than 30 calendar days)	Within 30 calendar days after the event ²	The date of the event
When you or your <u>eligible dependent(s)</u> either terminate Medicaid or CHIP (Children’s Health Insurance Program) coverage due to loss of eligibility or become eligible for a state premium assistance program or CHIP with respect to coverage under the Plan	Within 60 calendar days after the event ²	The date of the event

¹ Health Care Flexible Spending Accounts (HCFSAs) and Dependent Care Flexible Spending Accounts (DCFSAs) cannot be started or changed after Nov. 30 of each calendar year.

² If an enrollment action is not made within the allowable number of calendar days after the event, you won’t be able to make the enrollment action until the next annual enrollment period (absent another enrollment event), with coverage effective the first of the following calendar year.

Changing Your Coverage

Because you pay for coverage on a before-tax basis, IRS rules limit when you can make changes to your coverage. Other than during each year's annual enrollment, you can change your coverage election only if you experience a change in status for which you may be required or allowed to make changes to your coverage. The coverage election must be consistent with your change in status, and you cannot make a coverage change for financial reasons or because a provider stops participating in a network.

If you don't report the change to the Benefits Center within 30 calendar days¹ after the event date:

- You won't be able to change coverage until the next annual enrollment period; and
- The change won't be effective until the first of the following calendar year.

¹ This period is extended to 60 or 90 days in a few limited circumstances. See the chart on page G-5.

An HCFSa or DCFSA cannot be started or changed after Nov. 30 of each calendar year.

Because coverage change effective dates vary based on the event and the date of your enrollment action, contact the Benefits Center for further information about when the coverage change will be effective. To make changes, enroll online or call the Benefits Center.

 "Contacts," page A-1

"Change in status" changes may include these life events:

- Your marriage, divorce, legal separation or annulment;
- Death of an eligible dependent;
- Addition of an eligible dependent through birth, adoption, legal guardianship or placement for adoption. (Even if you already have *You + Two or More* coverage, you need to enroll your new eligible dependent(s) in order for their coverage to take effect);
- A relocation or move outside of the U.S. and/or network's coverage area;
- Loss of coverage;
- A Qualified Medical Child Support Order that requires you to provide medical/vision/dental coverage for a child;
- A change in employment status by you or your eligible dependent;
- A change in work schedule by you or your eligible dependent that changes coverage eligibility;
- A change in your eligible dependent's status;

✓ **NOTE:** If a relocation back to the U.S. initiates eligibility for a U.S. medical, vision and/or dental plan, or if your medical, vision and/or dental option is eliminated, your medical coverage will automatically default to the HDHP Base option, your vision coverage will automatically default to the Vision Base option and your dental coverage will automatically default to the Employee Dental Plan unless you enroll otherwise.

- You and/or your eligible dependents become eligible and enroll in or lose eligibility for Medicare or Medicaid;
- You and/or your eligible dependents become entitled to COBRA;
- The taking of or return from a leave of absence under the Family Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act of 1994; and
- You or your eligible dependents have a significant change in benefits or costs, such as day care costs, benefits from another employer, etc.

The Benefits Committee shall have the exclusive authority to determine if you're entitled to revoke an existing election as a result of a change in status or a change in the cost or coverage, as applicable, and its determination shall bind all persons.


-
- ✓ The Plan has the right to request reimbursement of any claims or expenses paid for an ineligible dependent. In addition, you may be subject to disciplinary action — up to and including termination of coverage for benefits in the applicable Plan or termination of employment by the employer for use of the Plan to pay expenses for an ineligible dependent.
-

If You Take a Leave of Absence

If you're on a leave of absence, you may continue your Flexible Spending Plan's HCFSA account contributions for yourself and your dependents during the approved leave period — provided the required contributions are made when they're due. If your leave of absence continues into the next calendar year, you can make contributions in the next year only if you're on a paid leave of absence. **Note:** Contributions to a DCFSA cannot be continued unless you're on a paid leave of absence.

- During your leave, you pay the same contribution for coverage that an active employee would pay.
 - If you're on a paid leave, your contributions will continue to be deducted from your paycheck on a before-tax basis.
 - If you're not receiving a paycheck from the Company, you'll make your contributions to the Company on an after-tax basis. (The Company will send you a bill.)
- When you return to work, the Company will resume deducting contributions from your paycheck on a before-tax basis, excluding any DCFSA contributions. You may contact the Benefits Center and request to make up any missing HCFSA contributions on a before-tax basis.

If you end your coverage while you're away on leave — or if your coverage is ended due to non-payment of required contributions — you must meet the same criteria as an active employee if you want to re-enroll in the Plan upon your return to work.

 “Who Is Eligible,” page G-3; “How to Enroll, Change or Cancel Contributions,” page G-3

✓ If You're on a Military Leave of Absence

See “USERRA Continuation Coverage” for general information regarding your Flexible Spending Plan coverage while you're on a military leave of absence.

 “USERRA Continuation Coverage,” page N-20

If You Have a Leave of Absence-Labor Dispute

If you're placed on a leave of absence-Labor Dispute, coverage for you and your dependents will end on the last day of the month in which the leave begins. You may continue coverage for yourself and your dependents during the leave under COBRA provisions. If you're eligible for retiree medical insurance, you may elect that coverage. See chart on page G-5 for coverage after you return to work. If you are on a leave of absence-Labor Dispute during a regularly scheduled annual enrollment, you will not be eligible and a special annual enrollment period will be provided after you return from the leave of absence-Labor Dispute.

What the Plan Costs

If you elect medical, vision and/or dental coverage under the ConocoPhillips Employee Medical Plan, ConocoPhillips Employee Vision Plan, ConocoPhillips Employee Dental Plan or ConocoPhillips Expatriate Medical and Dental Plan (with exclusions¹), you agree to pay your share of the cost for that coverage through automatic before-tax contributions to the FSPA.

If you enroll in an HCFSA or DCFSA, you pay the entire contribution amount. The Company does not contribute to these accounts. You choose the amount(s), up to Plan limits, you wish to contribute to each of these accounts. Your contributions are deducted from your paychecks on a before-tax basis throughout the plan year (Jan. 1 through Dec. 31).



"How Much You Can Contribute to Your HCFSA," page G-11; "How Much You Can Contribute to Your DCFSA," page G-14





The Benefits Committee has authority to make temporary changes in Plan provisions as appropriate, at the Benefits Committee's discretion, to respond to a natural or man-made emergency or disaster so participants can obtain covered services and benefits. In any such instance, the Benefits Committee shall adopt administrative procedures specifying the changes and the duration of such changes.

¹ An employee who is not a U.S. citizen or resident alien or who wants to cover dependents who are not U.S. citizens, resident aliens, residents of Canada or residents of Mexico is excluded.

How the Flexible Spending Plan Works

Here's a quick glance at the Flexible Spending Plan.

Type of Account	Description	Contributions and Limits
Flexible Spending Premium Account (FSPA)	Allows you to pay for your ConocoPhillips Employee Medical Plan, ConocoPhillips Employee Vision Plan, ConocoPhillips Employee Dental Plan or ConocoPhillips Expatriate Medical and Dental Plan (with exclusions ¹) coverage with before-tax contributions	Your before-tax contributions for the described plans
Health Care Flexible Spending Account (HCFSAs): <ul style="list-style-type: none"> A Limited Purpose HCFSAs; or A General HCFSAs  "About the Health Care Flexible Spending Accounts (HCFSAs) — General and Limited Purpose," page G-11	Allows you to use your before-tax contributions to reimburse yourself for your and your <u>eligible dependents</u> ² eligible health care expenses that aren't covered by your health, vision or dental care coverage	Provided you choose to contribute: <ul style="list-style-type: none"> The minimum contribution is \$120 per year The maximum contribution is \$3,300 per year²
Dependent Care Flexible Spending Account (DCFSA) <p>Note: You cannot use the DCFSA to pay health care expenses for your dependents.</p>  "About the Dependent Care Flexible Spending Account (DCFSA)," page G-13	Allows you to use your before-tax contributions to reimburse yourself for eligible dependent care expenses so you (and your spouse, if you're married) can work, or if your spouse is a <u>full-time student</u> or is <u>disabled</u> and unable to work	Provided you choose to contribute: <ul style="list-style-type: none"> The minimum contribution is \$120 per year The maximum contribution is \$5,000 per year (\$2,500 per year if you're married and file a separate income tax return)³


¹ An employee who is not a U.S. citizen or resident alien or who wants to cover dependents who are not U.S. citizens, resident aliens, residents of Canada or residents of Mexico is excluded.

² If your spouse is also an eligible ConocoPhillips employee, each of you may contribute up to \$3,300 to an HCFSAs.

³ The \$5,000/\$2,500 maximums will be reduced in certain circumstances (e.g., if your spouse also contributes to a DCFSA, if your spouse's income is less than \$5,000 or if your spouse is disabled or a full-time student).

 "How Much You Can Contribute to Your DCFSA," page G-14

With the Flexible Spending Plan:

- You're automatically enrolled in an FSPA if you elect medical, vision and/or dental coverage under the ConocoPhillips Employee Medical Plan, ConocoPhillips Employee Vision Plan, ConocoPhillips Employee Dental Plan or ConocoPhillips Expatriate Medical and Dental Plan (with exclusions⁴).
- Each plan year, you decide how much, if any, you wish to contribute to an HCFSAs and/or DCFSA. That amount is deducted in equal installments from your pay on a before-tax basis. **Note:** You must enroll each year if you want to contribute; your HCFSAs and DCFSA enrollments do **not** carry forward from year to year.
- As you incur eligible expenses during the year, you can be reimbursed from your HCFSAs and/or DCFSA.
 "HCFSAs and DCFSA Reimbursement Claims," page G-17
- Expenses must be incurred in the same plan year in which the contribution was made, and only expenses incurred while you're participating in the Plan are eligible for reimbursement.

⁴ An employee who is not a U.S. citizen or resident alien or who wants to cover dependents who are not U.S. citizens, resident aliens, residents of Canada or residents of Mexico is excluded.

- All requests for reimbursement for expenses incurred during the year must be filed by June 30 of the following calendar year.
- Due to IRS regulations, any money remaining in your account(s) after June 30 of the following calendar year is forfeited. However, any claims properly filed but not yet paid prior to June 30 will be paid if eligible.

 “Use or Lose,” page G-16

Flexible Spending Plan Tax Savings & Considerations

Savings

Because you don’t pay taxes either before the contributions go into your account or when they are paid out to you, your “out-of-pocket” cost for eligible health care and dependent care expenses is reduced by the taxes you otherwise would have paid on this money. Let’s look at an example:

Example: Tax Savings Using the General HCFSa and the DCFSa		
	When Bill pays eligible health care and dependent care expenses with before-tax dollars¹ ...	When Bill pays these expenses using after-tax dollars¹ ...
Bill’s adjusted gross income	\$ 70,000	\$ 70,000
Before-tax contributions to a General HCFSa and DCFSa	– 3,200 (General HCFSa) – 3,500 (DCFSa)	– 0 (General HCFSa) – 0 (DCFSa)
Taxable income	63,300	70,000
Taxes (assumes 15% federal, 7.65% FICA)	– 14,337	– 15,855
Remaining income	48,963	54,145
After-tax costs for health care and dependent care expenses	– 0 (health care) – 0 (dependent care)	– 3,200 (health care) – 3,500 (dependent care)
Spendable income	\$48,963	\$47,445
Tax savings from using a General HCFSa and DCFSa	\$ 1,518	

¹ These calculations don’t take into account itemized deductions, personal exemptions, state taxes or the Child and Dependent Care Credit.

✓ Social Security Tax Considerations

Because before-tax contributions to the Flexible Spending Plan reduce your income for Social Security purposes, your Social Security benefits could also be slightly reduced at retirement. For most Plan participants, Plan contributions should have a minimal impact, if any, on future Social Security benefits. However, if you’re concerned, you should contact the nearest Social Security office or ask a financial planner for advice.

Considerations

When you contribute to the HCFSAs and/or the DCFSAs, you lower the amount of Social Security tax, Medicare tax, federal income tax and, in most areas, state and local income tax withheld from your paycheck. On the other hand, claiming tax deductions for your unreimbursed health care expenses or taking the Child and Dependent Care Credit for your unreimbursed dependent care expenses reduces the amount of tax you pay when you file your annual income tax return.


Depending on your personal situation, you may save more in taxes using the tax deduction and/or tax credit than by participating in the HCFSAs or DCFSAs. **You should consult a tax advisor to determine which alternative offers you the greater tax advantage.**

HCFSAs	You cannot claim a tax deduction on your federal income tax return for the same expenses that are reimbursed through an HCFSAs. Qualification for a tax deduction is based on your unreimbursed expenses and your adjusted gross income.
DCFSAs	Qualification for the Child and Dependent Care Credit on your federal income tax return depends on your adjusted gross income and your eligible dependent care expenses. All employees (whether living in the U.S. or overseas) who reimburse their dependent care expenses through a DCFSAs are required to file IRS Form 2441 with their federal income taxes. For more information, refer to the Internal Revenue Service website for <i>IRS Publication 503, "Child and Dependent Care Expenses"</i> at www.irs.gov .

About the Health Care Flexible Spending Accounts (HCFSAs) — General and Limited Purpose

There are two Health Care Flexible Spending Account (HCFSAs) options — the General HCFSAs and the Limited Purpose HCFSAs.

- The General HCFSAs is available if you are enrolled in the HDHP or HDHP Base medical option without an HSA.
- The Limited Purpose HCFSAs is available if you are enrolled in the HDHP or HDHP Base medical option with an HSA.

 *"The HDHP and HDHP Base Options and Health Savings Accounts (HSAs)," page B-19*

Your enrollment in an HCFSAs is independent of your enrollment in a ConocoPhillips medical option. You can only enroll in one HCFSAs at a time. Unless otherwise noted, the information in this section applies to both HCFSAs options.



How Much You Can Contribute to Your HCFSAs

Each plan year, you can contribute up to \$3,300 to your HCFSAs, in whole-dollar amounts. If your spouse is also employed by the Company, your spouse can also contribute up to \$3,300 to his or her separate HCFSAs. These annual maximums apply whether you're enrolled in the HCFSAs for the entire calendar year or only for a partial year.

If you choose to contribute, the minimum HCFSAs contribution is \$120 per year.


Eligible Dependents Under the HCFSAs

You can use your HCFSAs to pay eligible health care expenses incurred by your dependents — including those who are disabled or included in a Qualified Medical Child Support Order (QMCSO). Your dependents for HCFSAs purposes may or may not be the same dependents you cover under your medical, vision or dental coverage. For HCFSAs purposes, eligible dependents include:

- Persons covered per a QMCSO;
 *"Qualified Medical Child Support Order (QMCSO)," page N-5*
- Persons who would qualify as your eligible dependents under the ConocoPhillips Employee Medical Plan, ConocoPhillips Employee Vision Plan, ConocoPhillips Employee Dental Plan or ConocoPhillips Expatriate Medical and Dental Plan; or
 *"Glossary," page O-6*
- Persons you may claim as dependents on your federal income tax return.

Eligible HCFSAs Expenses

- ✓ For more detailed information about expenses that are and are not eligible for HCFSAs reimbursement, contact the [Claims Administrator](#), or refer to the Internal Revenue Service website at www.irs.gov for *IRS Publication 502, "Medical and Dental Expenses."*

 "Ineligible HCFSAs Expenses," page G-13; "Contacts," page A-1

Through your HCFSAs, you can reimburse yourself for IRS-qualified medical, dental, prescription drug, vision, hearing, over-the-counter medications and menstrual product expenses for you and your eligible dependents. In order to qualify, the expenses **cannot** be:

- Paid by any other plan;
- Paid through a health savings account (HSA) if you're participating in such an account; or
- Applied toward your annual HDHP or HDHP Base deductible (applicable only if you have an HSA).

These eligible expenses generally include any item that would qualify for a medical deduction on your federal income tax return, provided the expense is incurred while you're participating in the HCFSAs.

- ✓ Any expense for which you have been reimbursed through your HCFSAs cannot also be claimed as a deduction on your income tax return.
-

To the extent that they aren't paid by any other coverage, through an HSA or claimed as an income tax deduction, the following are **examples** of some of the out-of-pocket expenses that are eligible for reimbursement through the HCFSAs (eligibility of these examples can change at any time):

- Eligible medical, dental, vision and hearing expenses not reimbursed by other plans, including annual deductible, copay and coinsurance amounts. **Note:** If you're enrolled in a **Limited Purpose** HCFSAs, only preventive care expenses, dental and vision expenses can be reimbursed through the HCFSAs prior to meeting your annual HDHP or HDHP Base deductible;
- Eyewear (including glasses, contact lenses and contact solution);
- Nursing services;
- Acupuncture performed by a licensed practitioner;
- Treatment of alcohol or drug dependency;
- Diabetic supplies;
- Hospice care;
- Prescription drugs;
- Purchase or rental of durable medical equipment (such as wheelchairs, crutches, etc.);
- Prosthetic and orthopedic devices;
- Vision correction surgery or procedures;
- Vitamin and mineral supplements prescribed for a specific illness or condition;
- Special schooling for physical or learning impairments;
- Charges over reasonable and customary limits;
- Drugs and weight loss programs, if physician documents they are medically necessary due to obesity or other medical conditions;
- Smoking cessation (if medically necessary, and the services/supplies are provided by or prescribed by a physician);
- Travel expenses required to receive medical care;
- Hearing aids and fitting;
- Menstrual products;
- Braille books and magazines; and
- Over-the-counter medications (in reasonable quantities).

✓ Important Note About Orthodontia

To obtain HCFSa reimbursement for orthodontia treatment, you have a choice of three reimbursement payment options. Contact the [Claims Administrator](#) for details. All reimbursements are paid as long as there is a remaining balance in your HCFSa enrollment election, even if you have not yet contributed enough to the HCFSa to fund the reimbursement.



“HCFSa Reimbursement Claims,” page G-17; “Contacts,” page A-1

Ineligible HCFSa Expenses

You can’t use the HCFSa to reimburse yourself for expenses that aren’t recognized as legitimate deductions under IRS regulations. **Examples** of these ineligible expenses include — but are not limited to:

- Health care services received before your participation in the HCFSa begins or after your participation ends;
- Most cosmetic surgery, or drugs used for cosmetic purposes;
- Custodial care;
- Funeral and burial expenses;
- Health club dues;
- Social activities, such as dance lessons (even if recommended by a physician);
- Weight loss programs that haven’t been determined as medically necessary;
- Costs for health care coverage — including your costs for medical, vision or dental coverage under the ConocoPhillips Medical and Dental Assistance Plan;
- Premiums for life or accident insurance;
- Expenses reimbursed through another policy, plan or program;
- Expenses claimed as a deduction or credit on your federal tax return;
- Babysitting;
- Exercise equipment;
- Maternity clothes; and
- Special dietary food or drink.

About the Dependent Care Flexible Spending Account (DCFSA)

Expenses that are eligible for reimbursement through the Dependent Care Flexible Spending Account (DCFSA) include the cost of certain types of dependent care that you must provide for your dependent(s) so that you — and your spouse, if you’re married — can work or seek employment.

If you’re married, your spouse must be gainfully employed, a full-time student for at least five months of the year, or disabled and unable to care for your dependent children in order for your dependent care expenses to qualify for reimbursement through the DCFSA.

How Much You Can Contribute to Your DCFSA

If you choose to contribute to a DCFSA, the minimum contribution is \$120 per year.

The annual maximum DCFSA contribution varies based on your personal situation, as shown below. These annual maximums apply whether you're enrolled in the DCFSA for the entire calendar year or only for a partial year.

If you're:	Your maximum annual contribution is:
Single	The lesser of \$5,000 or your earned income
Married, filing a joint income tax return	The lesser of \$5,000 or the earned income of the lower-paid spouse
Married, filing separate income tax returns	The lesser of \$2,500 or the earned income of the lower-paid spouse
Married, and your spouse also contributes to a DCFSA through his or her employer	Your and your spouse's combined contributions cannot exceed the \$5,000 or \$2,500 maximums shown above. (Any contributions above those maximums will be treated as taxable income by the IRS.)
Married, and your spouse is either a <u>full-time student</u> or <u>disabled</u>	<div>\$250* for one dependent</div> <div>\$500* for two or more dependents</div> <div><small>* Multiplied by the number of months your spouse is a <u>full-time student</u> or <u>disabled</u> during the year.</small></div>

Eligible Dependents Under the DCFSA

For purposes of the DCFSA, your eligible dependents are defined by federal tax law to include the following individuals who spend at least eight hours a day in your home:

- Your dependent children (your natural, legally adopted, or placed for adoption son or daughter or your stepson or stepdaughter) **under age 13** whom you claim as your dependent on your federal income tax return¹;
- Your disabled spouse, provided he or she is physically or mentally incapable of self-care and has the same principal place of abode as you for more than 50% of the current calendar year; and
- Any person¹ age 13 or older whom you claim as your dependent on your federal income tax return, provided:
 - The person is physically or mentally incapable of self-care;
 - The person has the same principal place of abode as you for more than 50% of the current calendar year; and
 - You provide more than 50% of the person's financial support for the current calendar year.

Note: The following dependents are **not** eligible for purposes of a DCFSA:

- Your domestic partner; or
- Your domestic partner's child(ren).

¹ In the case of divorced or separated parents, a dependent child is considered to meet these requirements — even if the divorced or separated parent doesn't claim the child on his or her tax return — if the parent is the custodial parent and all other requirements to claim the child as a dependent on his or her tax return are met.

Eligible DCFSA Expenses


- ✓ For more detailed information about expenses that are and are not eligible for DCFSA reimbursement, contact the [Claims Administrator](#), or refer to the Internal Revenue Service website at www.irs.gov for *IRS Publication 503, "Child and Dependent Care Expenses."*

 *"Ineligible DCFSA Expenses," at right; "Contacts," page A-1*

For purposes of the DCFSA, eligible expenses generally include any item that would qualify for the federal Child and Dependent Care Credit on your federal income tax return, provided the expense is incurred while you're participating in the DCFSA.

- ✓ You cannot use the DCFSA to reimburse yourself for any expense that you claim as a tax credit on your income tax return.

In addition, you cannot use your DCFSA to reimburse yourself for dependent **health care** expenses. Those expenses can be reimbursed only through an HCFSA.

 *"About the Health Care Flexible Spending Accounts (HCFSA) — General and Limited Purpose," page G-11*

- ✓ The Company subsidy you receive for child care at Bright Horizon's The Play (Company child care facility in Midland, TX) will count toward your \$5,000 DCFSA annual maximum. As a result, if your accumulated total of DCFSA contributions and total child care subsidy exceeds the \$5,000 limit, your DCFSA contributions will be stopped to avoid exceeding the IRS limit. Any subsequent child care subsidy for the remainder of the year will be imputed into your income and subject to regular income tax as required by the IRS. See hr.conocophillips.com for Family Life Benefits Plan information.

Some **examples** of eligible dependent care expenses include:

- A licensed day-care center or nursery school that provides services to at least six nonresident individuals and receives a fee for its services;
- A caretaker or companion who works in or out of your home during working hours and provides you with a Social Security number for tax purposes;
- Family day-care or adult day-care centers;

- Expenses associated with before- and after-school day care;
- Day-care expenses for children or the elderly — including meal preparation, housecleaning and assistance with dressing;
- Transportation to or from the place where care is provided if provided by the caregiver; or
- Day camp, provided the dependent doesn't remain at the camp overnight.

Ineligible DCFSA Expenses

You can't use the DCFSA to reimburse yourself for dependent care expenses that aren't recognized by the IRS. **Examples** of DCFSA ineligible expenses include — but are not limited to:

- Dependent care that allows you to participate in leisure activities;
- Payments to one of your dependents or to someone in your immediate family;
- Care outside of your home — unless your eligible dependent spends at least eight hours per day in your home;
- Food or school expenses, including kindergarten;
- Transportation to or from the place where care is provided if provided by anyone other than the caregiver;
- Care provided in full-time residential institutions — such as nursing homes and homes for the mentally disabled;
- Care that allows you or your spouse to attend school part-time or to attend educational programs, meetings or seminars;
- Dependent care expenses incurred during periods you are absent from work, excluding absences shorter than your dependent-care payment commitment, such as daily, weekly or monthly;
- Overnight camp of any kind; or
- Expenses you plan to take as a Child and Dependent Care Credit on your federal income tax return.

IRS Regulations/Limitations

In exchange for the tax advantages offered by the Flexible Spending Plan, the IRS applies strict rules and limitations to them. Be sure you read and understand the following information before electing to contribute to an HCFSAs or DCFSA.

Use or Lose

Federal law requires that you forfeit (lose) any HCFSAs and DCFSA contributions for which you haven't incurred an eligible expense by the end of the plan year (Dec. 31). Any unused contributions remaining in your account(s) can't be returned to you or "carried over" to the following plan year. For this reason, you should carefully estimate your annual eligible health care and/or dependent care expenses before making your Flexible Spending Plan account elections.

However, you have until June 30 of the following year to submit claims for expenses incurred in the previous plan year. Requests must be postmarked or electronically submitted to the Claims Administrator by June 30 of the following year in order to be eligible for reimbursement.

 "HCFSAs and DCFSA Reimbursement Claims," page G-17

✓ According to IRS regulations, forfeited employee HCFSAs and DCFSA contributions may be used to help pay expenses of administering the Plan. After paying these administrative expenses, any remaining forfeited employee contributions will be distributed to current Plan participants on a per capita basis (equal distribution method).

In addition, any HCFSAs or DCFSA benefit payments that have gone unclaimed (i.e., uncashed benefit checks) will be forfeited and applied as described in the prior paragraph after June 30 of the second year following the year in which the expense was incurred.

Separate Accounts

The money contributed to your HCFSAs can be used **only** for eligible health care expenses you incur during the same period in which your HCFSAs contributions are made; and the money contributed to your DCFSA can be used **only** for eligible dependent care expenses you incur during the same period in which your DCFSA contributions are made.

Because these accounts are separate, you cannot:

- Use funds in your HCFSAs to pay for dependent care expenses or the funds in your DCFSA to pay for health care expenses or for medical, vision and/or dental insurance; or
- Transfer funds between the two accounts.

If Your Flexible Spending Plan Coverage Ends

If your Plan coverage ends before the end of the plan year for any reason, contributions to your HCFSAs and DCFSA stop with your last paycheck.

 "When Coverage Ends," page G-19

- You have up to June 30 of the following calendar year after an expense is incurred to submit claims for any eligible expense you incurred up to your coverage end date.
- According to IRS regulations, if you didn't incur any eligible expenses before your coverage end date — or if your contributions exceed your eligible expenses — you'll forfeit any funds remaining in your account.
- To avoid forfeiting funds remaining in your HCFSAs, you can elect to continue your participation by making after-tax contributions to your HCFSAs until the end of the plan year through COBRA continuation coverage. By making that election, you can be reimbursed for eligible expenses you incur through the end of the plan year. This option does **not** apply to the DCFSA.

 "COBRA Continuation Coverage," page N-12

HCFSA and DCFSA Reimbursement Claims

- ✓ As you incur eligible expenses during the year, you can be reimbursed from your HCFSA and/or DCFSA. Expenses must be incurred in the same plan year in which the contribution was made, and only expenses incurred while you're participating in the Plan are eligible for reimbursement. The Flexible Spending Plan Claims Administrator or the Benefits Center can answer questions you may have about procedures for completing and submitting claims for HCFSA or DCFSA reimbursement. Send your HCFSA and/or DCFSA claims and supporting documentation to the Claims Administrator at the address shown in the "Contacts" section.

 "Contacts," page A-1

HCFSA and DCFSA reimbursements are made on a daily basis. You can receive your reimbursements:

- By direct deposit to your bank account; or
- By mail with a check sent to your address on file.

You can enroll in, change or cancel Flexible Spending Plan account direct deposit online at any time.

 "Contacts," page A-1

Flexible Spending Plan account claims must be received no later than June 30 of the year following the year in which the service was rendered. For example, a claim dated March 2025 must be received no later than June 30, 2026. It will be considered filed on the date it's received by the Claims Administrator. Claims received after the June 30 deadline are not eligible for payment under the Plan. Your estate can file a claim subject to the same provisions you had.

✓ Tracking Your HCFSA and DCFSA Activity

To help track your Plan activity, your paycheck statement identifies the amount deducted for your HCFSA and/or DCFSA during each pay period in which a contribution is made.

Each reimbursement claim paid will contain information showing the expenses claimed, the amounts reimbursed and the current status of your HCFSA or DCFSA. In addition, you can manage your account online or you can contact the Claims Administrator to obtain the current balance of your HCFSA and/or DCFSA accounts.

If you have a smart phone, you can also have mobile access. Online services include:

- Register for mobile access user name and password.
- View account information.
- Submit claims for reimbursement.
- Order FSA debit cards for spouse/dependents.
- View and customize account alerts.
- Read FSA news articles of interest.

 "Contacts," page A-1

HCFSA Reimbursement Claims


The full amount of your annual contribution to the HCFSA (minus any reimbursements that have already been paid to you) is available for reimbursement at any time during the plan year. You don't need to wait for contributions to accrue each month before receiving reimbursement for eligible expenses. For example, if you elect an annual HCFSA contribution of \$1,000, you can request reimbursement for an eligible \$1,000 expense in March, even though you haven't yet contributed that amount to the account.

FSA Debit Card Reimbursement Option

If you enroll to make contributions into the HCFSA, you will automatically receive an FSA debit card. You can request additional FSA debit cards for your spouse/dependents. Use of the card is limited to qualified retail establishments for eligible products and services. These establishments have a system that automatically recognizes items eligible for flexible spending accounts under IRS regulations. The system will decline purchase of items not eligible for flexible spending accounts.

If an expense is covered by a health care plan — including the ConocoPhillips Medical and Dental Assistance Plan — a claim for that expense must be submitted first to your health care Claims Administrator. You'll receive an Explanation of Benefits (EOB) statement, which verifies how much that plan paid and how much you must pay. Keep all your receipts if you use a FSA debit card because you may be asked to submit your receipts to the Claims Administrator for proof of an eligible expense. Copays you pay while covered by a ConocoPhillips benefit plan don't require you to submit receipts. **NOTE:** You'll receive an email from the Claims Administrator when your receipts are required. You can submit a copy of the receipt and/or your Explanation of Benefits (EOB) with a claim form online, by fax or by mail. The Claims Administrator's mobile app allows you to take a picture of the receipt and submit it online.

Use of the FSA debit card for your HCFA reimbursement is not recommended if you're covered by more than one medical, vision or dental plan and have coordination of benefits or have a domestic partner. HCFA claims must be filed manually for these situations.

 *"Coordination of Benefits (COB)," page B-48, page E-14 and page F-18; "Manual Reimbursement Option," below*

Manual Reimbursement Option

If you don't elect to use the FSA debit card option — or you have claims for services that can't be processed through that option — you'll need to file your claim online, by fax or by mail. You can file online at www.inspirafinancial.com or by calling the Claims Administrator.

 *"Contacts," page A-1*

Your claim must include evidence of your payment of the expense — such as a receipt or an Explanation of Benefits (EOB). Be sure to keep copies of all documents sent to the Claims Administrator.

 *"Contacts," page A-1*

DCFSA Reimbursement Claims

Under federal regulations, you can be reimbursed for expenses only up to the amount deposited into your DCFSA as of the date your reimbursement request is received by the Claims Administrator. For example, if you have \$150 in your DCFSA and submit a reimbursement request for \$350, you would be reimbursed for \$150. The remaining \$200 would be reimbursed after you've contributed that amount to your DCFSA.

You need to submit a claim form online, by fax or by mail in order to request reimbursement from the DCFSA. You can file online at www.inspirafinancial.com or by calling the Claims Administrator.

 *"Contacts," page A-1*

Claim Review and Appeal Procedure

For information about when to expect a response to your claim from the Claims Administrator and/or Appeals Administrator or how to file an appeal if your claim is denied, refer to the "Claims and Appeals Procedures" section.

 *"Claims and Appeals Procedures," page N-26*

When Coverage Ends

- ✓ If you become ineligible for Plan coverage, you may be eligible to continue HCFSA participation through COBRA continuation coverage, but only through the last day of the calendar year in which Plan coverage ended. FSPA and DCFSA participation cannot be continued.



“COBRA Continuation Coverage,” page N-12

Your coverage and expense reimbursement eligibility will end on the earliest of the following events:

- The last day of the month in which your employment ends for any reason;
- The last day of the month in which you no longer meet the Plan’s eligibility requirements;



“Who Is Eligible,” page G-3

- The last day of the month in which your coverage is terminated for any other reason not stated in this section;
- The last day of the month in which you don’t make the required contributions;
- The last day of the month in which your leave of absence-Labor Dispute begins;
- If you have continued coverage during a leave of absence and you don’t return to work as an employee at the end of the leave, the last day of the month in which the earliest of the following events occurs:
 - The leave expires; or
 - You first notify the Company that you don’t intend to return to work;
- The date of your death; or
- The date on which the Flexible Spending Plan is terminated.

Employee Assistance Plan



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<i>Dependent Certification Rules</i>	<i>H-4</i>
How to Enroll	<i>H-5</i>
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✓ Please refer to the Glossary beginning on page O-1 for the definitions of underlined terms used throughout this SPD.

📖 “Glossary,” page O-1

In this chapter, the term “Company” refers to ConocoPhillips and the other companies that have adopted this Plan.

Introduction

The ConocoPhillips Employee Assistance Plan (EAP) provides you and your eligible dependents with access to professional assessment, short-term counseling and referral services — prepaid by the Company — to help in resolving personal issues that arise in your work and home life. You and your eligible dependents are automatically enrolled in this coverage on your first day of work as an eligible employee. Use of this Plan is completely voluntary.

📖 “Who Is Eligible,” page H-3

Benefits for employees eligible for the U.S. Inpatient Medical and Dental Plan or the Expatriate Medical and Dental Plan are provided by TELUS Health and are not described in this SPD. Sections of this SPD handbook that do not apply will be indicated.



Who Is Eligible

Employee Eligibility

If you're an active, regular full-time or regular part-time¹ employee, you're eligible to participate in the Plan if you're:

- A U.S. citizen or resident alien employee working within or outside the U.S. (includes rotators) who is paid on the direct U.S. dollar payroll²;
- A U.S. citizen or resident alien employee working within or outside the U.S. (includes rotators) who is paid on the direct U.S. dollar payroll² and who is on a personal, disability or military leave of absence or on a family medical leave of absence; or
- An employee who is eligible for the U.S. Inpatient Medical and Dental Plan or the Expatriate Medical and Dental Plan.³


You're **not** eligible to participate in the Plan if your classification isn't described in this section. For example, temporary employees, intermittent employees, independent contractors, contingent workers, contract workers, leased employees and commission agents aren't eligible for the Plan.

¹ Regular part-time employees must be regularly scheduled to work on average at least 20 hours per week.

² Direct U.S. dollar payroll means that payroll check is written in U.S. dollars by a U.S. company participating in the Plan and is not converted to another currency before being paid to the employee.

³ Coverage is provided by TELUS Health.

Note: Special rules apply if your spouse/domestic partner is also a Company employee.

 *If Your Eligible Spouse/Domestic Partner Is Also a Company Employee," below*

-
- ✓ Contact the Benefits Center for questions about whether your collective bargaining agreement expressly provides for your participation in the Plan.

 *"Contacts," page A-1*

If Your Eligible Spouse/Domestic Partner Is Also a Company Employee

-
- ✓ Review the rules used in determining "spouse" and "domestic partner" eligibility.

 *"Dependent Eligibility," page H-4*

If both you and your eligible spouse/domestic partner work for ConocoPhillips, you can be enrolled for coverage both as an employee and as a spouse/domestic partner. However, limits apply to the total amount of coverage you can receive for yourselves and for your covered dependent children. See "How the Employee Assistance Plan Works" for details.

 *"How the Employee Assistance Plan Works," page H-6*

Dependent Eligibility

Your eligible dependents may also be eligible for coverage. Eligible dependents¹ include your:

- Spouse (including your state-recognized common-law spouse²; excluding a spouse after a divorce or separation by a legal separation agreement³) or your domestic partner; and
- Child, as follows:
 - Your biological, legally adopted (includes foreign adoptions) or placed for adoption child;
 - Your domestic partner's biological or legally adopted child (includes foreign adoptions), provided the child receives over 50% of his or her support from you **and** has the same principal place of abode as you for the tax year;
 - Your child under a legal guardianship agreement issued by a court; or
 - Your stepchild, provided the parent is your spouse and you and your spouse either remain married and reside in the same household, or your spouse died while married to you.

You can cover the child/stepchild/guardianship child/domestic partner's child if he or she is:

- Under age 26⁴; or
- Age 26 or older, provided the child was disabled prior to age 26 and coverage is approved by the Plan within 30 calendar days of his or her reaching age 26 or initial eligibility after age 26⁵.

¹ If your coverage is provided by TELUS Health, refer to the Certificate of Coverage for any additional eligibility provisions.

² The common-law marriage must be consummated in a state that recognizes common-law marriage, and all state requirements must have been met.

³ The Plan will recognize a decree of legal separation or court-approved legal written separation agreement of any kind — including a court-approved separate maintenance agreement.

⁴ Your child is considered an eligible dependent up to age 26 regardless of student status, marital status, employment status and/or IRS dependent requirements.

⁵ A disabled dependent over age 26 who is disabled prior to age 26 may also become an eligible dependent if such disabled dependent experiences a qualified change in status and becomes eligible for the Employee Medical Plan.

Note: A dependent is **not** eligible if he or she:

- Is on active duty in any military service of any country (excluding weekend duty or summer encampments);
- Is not a U.S. citizen, resident alien or resident of Canada or Mexico;
- Is the child of a domestic partner and has been claimed as a dependent on your domestic partner's or on anybody else's federal tax return for the year of coverage;
- Is the child of a domestic partner and the domestic partnership between you and your domestic partner has ended, even if your domestic partner's child continues to reside with you;
- Is the child of a surrogate mother (is not considered the child of the egg donor) and does not qualify as a dependent otherwise;
- Is no longer your stepchild due to divorce, legal separation or annulment;
- Is a grandchild not legally adopted by you;
- Is placed in your home as a foster child; or
- Is in a relationship with you that violates local law.

Dependent Certification Rules

Accessing EAP services for an ineligible dependent or failure to provide required evidence of eligibility is considered by the Plan to be evidence of fraud and intentional misrepresentation of a material fact that will trigger rescission that may be back to the date on which your dependent no longer qualifies as an eligible dependent. If the coverage is rescinded, the Plan will give the participant a 30-calendar-day advance written notice prior to rescission. If you access EAP services for an ineligible dependent, the Plan has the right to request reimbursement of any claims or expenses paid for that dependent. In addition, you may be subject to disciplinary action — up to and including termination of coverage for benefits in the applicable Plan or termination of employment by the employer for an ineligible dependent using services under the Plan.

Proof documenting dependent eligibility must be provided per rules, which may include requirements for self-certification in addition to documentation, adopted by the Benefits Committee. Failure to provide the certification and/or the requested documents verifying proof of dependent eligibility in a timely manner may delay or prevent your dependent's coverage, and you generally will not be able to have the coverage reinstated until the next annual enrollment period unless you experience a change in status event. If coverage is added at a later date, you will once again be asked to provide the appropriate documentation of dependent status. Contact the Benefits Center for details or if you have any questions about this requirement.

 *"Contacts," page A-1*

How to Enroll

You don't need to enroll for EAP coverage. It begins automatically on the first date you meet the Plan's eligibility requirements.

 *"Employee Eligibility," page H-3*

If You Take a Leave of Absence

If you're on a leave of absence, coverage for you and your eligible dependents continues during the approved leave period.

✓ If You're on a Military Leave of Absence

See "USERRA Continuation Coverage" for general information regarding your EAP coverage while you're on a military leave of absence.

 *"USERRA Continuation Coverage," page N-20*

If You Have a Leave of Absence-Labor Dispute

If you're placed on a leave of absence-Labor Dispute, coverage for you and your eligible dependents will end on the last day of the month in which the leave begins. You may continue coverage for yourself and your eligible dependents during the leave under COBRA provisions.

✓ The Benefits Committee has authority to make temporary changes in Plan provisions as appropriate, at the Benefits Committee's discretion, to respond to a natural or man-made emergency or disaster so participants can obtain covered services and benefits. In any such instance, the Benefits Committee shall adopt administrative procedures specifying the changes and the duration of such changes.

What the Plan Costs

The Company pays the entire cost of coverage under this Plan.

How the Employee Assistance Plan Works

✓ This section does not apply to employees eligible for the U.S. Inpatient Medical and Dental Plan or the Expatriate Medical and Dental Plan.

The EAP provides confidential counseling and support services designed to help you and/or your eligible dependents resolve issues quickly. Just contact the Plan's Claims Administrator by phone or website, to access EAP resources and referrals to professional providers and to obtain advance approval in order to receive benefits under the Plan. **If you fail to receive authorization, EAP benefits will NOT be paid.**

 "Contacts," page A-1

Counselors are available to help you **24 hours a day**, 365 days a year for a range of issues, including:

- Marital and family issues;
- Parenting issues;
- Interpersonal relationship issues;
- Substance use disorder concerns;
- Depression;
- Stress and anxiety;
- Career transition issues;
- Grief and loss; and
- Coping with illness.

When you contact the Claims Administrator, an experienced professional will answer your questions or arrange for counseling with an affiliate provider who can help you develop an action plan to resolve your issues.

For each eligible participant, the Plan provides up to **eight** face-to-face or telephone/video counseling sessions per issue within a 12-month period. Parental coaching of up to three sessions per member per year is available from the Claims Administrator. If the affiliate provider determines that you require professional services beyond those available through the Plan, you may be referred to an appropriate resource through your own health plan/insurance or a community resource. **You'll be responsible for all costs incurred for any additional services that are beyond those available through this Plan.**

The Plan also offers **24-hour access** to a comprehensive source of self-guided information and a library of educational materials on a wide variety of mental health topics available online. You'll find information on:

- Stress and relationship issues;
- Building Resilience;
- Mindfulness; and
- Everyday resource articles.

In addition, the site offers a range of self-assessment tools and interactive trainings, as well as news briefs and feature stories, which are updated regularly. See "Contacts" for how to access EAP resources.

 "Contacts," page A-1

✓ Use of the Plan or other available resources has no effect on your continued employment, pay, promotions or other incidents of employment.

How to File a Claim

Since there is no cost to Plan participants for EAP services, there are no claims to file for reimbursement. However, if you feel you have been denied a benefit under the Plan, you can appeal the denial.

 *"Claims and Appeals Procedures," page N-26*

-
- ✓ Claims filed by the provider under the Plan must be received no later than Dec. 31 of the year following the date service was provided.
-

When Coverage Ends

-
- ✓ If you and/or your dependents become ineligible for Plan coverage, the ineligible person may be eligible to continue coverage through COBRA continuation coverage.

 *"COBRA Continuation Coverage," page N-12*

Your coverage will end on the earliest of the following events:

- The last day of the month in which your employment ends for any reason;
- The last day of the month in which you no longer meet the Plan's eligibility requirements;

 *"Employee Eligibility," page H-3*

- The last day of the month in which your coverage is terminated for any other reason not stated in this section;
- The last day of the month in which your leave of absence-Labor Dispute begins;
- If you have continued coverage during a leave of absence and you don't return to work as an employee at the end of the leave, on the last day of the month in which the earliest of the following events occurs:
 - The leave expires; or
 - You first notify the Company that you don't intend to return to work;
- The date of your death; or
- The date on which the Employee Assistance Plan is terminated.

Coverage for your eligible dependents ends on the earliest of the following events:

- The last day of the month in which your coverage ends for any reason;
- The date on which your dependent no longer qualifies as an eligible dependent as defined by the Plan.
Exception: A coverage loss due to a child dependent's age or divorce/legal separation/annulment from spouse/dissolution of domestic partnership will occur the last day of the month in which the event occurred;
- The last day of the month in which coverage for your dependent(s) is terminated for any other reason not stated in this section;
- The date on which your dependent becomes eligible for coverage as a Company employee; or
- The date of your dependent's death.

Employee Life Plan

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✓ Please refer to the Glossary beginning on page O-1 for the definitions of underlined terms used throughout this SPD.

📄 “Glossary,” page O-1

In this chapter, the term “Company” refers to ConocoPhillips and the other companies that have adopted this Plan.

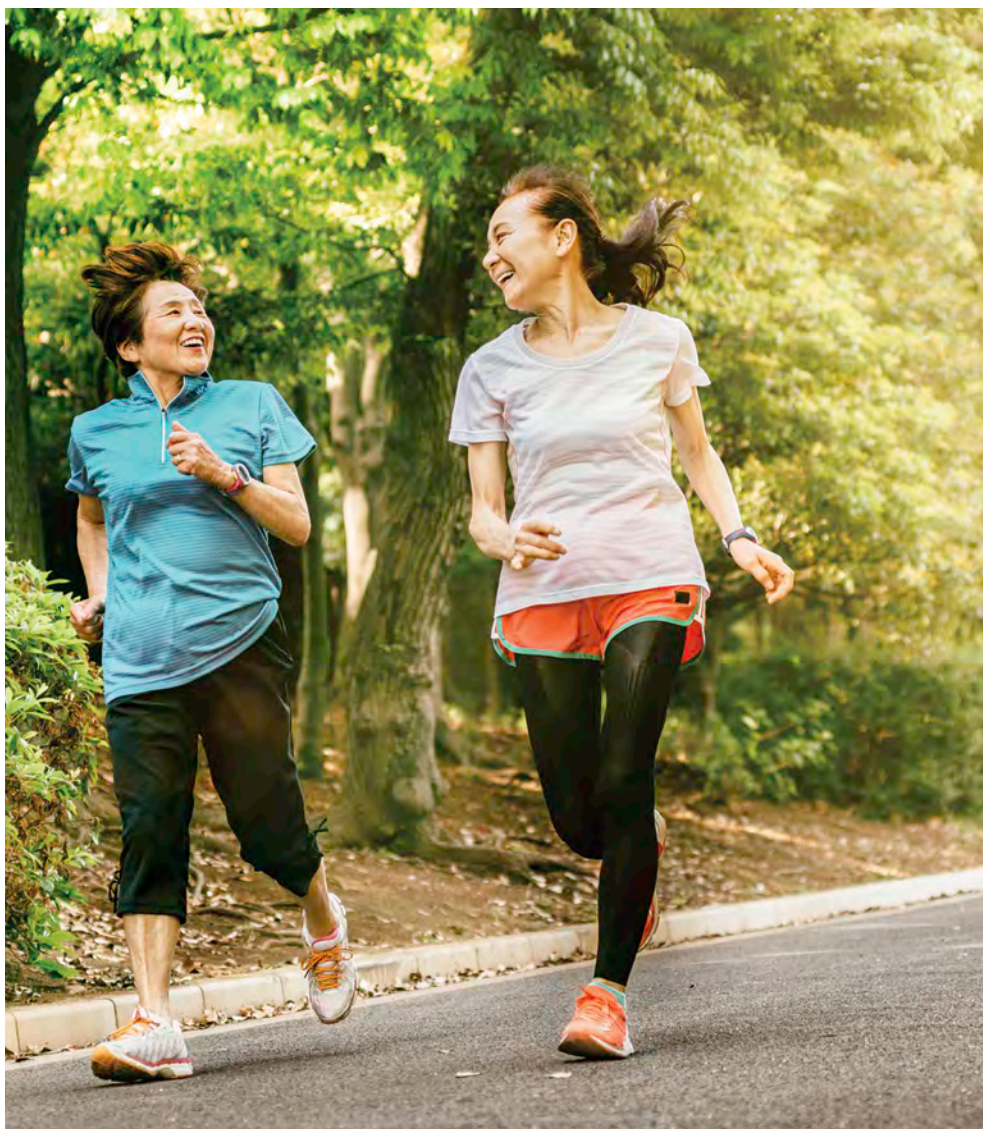
✓ For information on retiree life benefits, refer to the separate *Retiree Benefits Handbook* available from the Benefits Center or on hr.conocophillips.com.

Introduction

The ConocoPhillips Group Life Plan (the Plan) provides your family with valuable financial protection in the event of your death or the death of a covered dependent.

The Plan includes a Company-provided basic life benefit that helps protect your family in the event of your death. If you are eligible for basic life, you will also have travel assistance coverage. In addition, a Company-provided occupational accidental death (OAD) benefit is payable if you die as a result of a covered accident while you're on the job.

For added protection, you can purchase additional supplemental life coverage for yourself and dependent life coverage for your eligible dependents (your spouse and eligible dependent children).



Who Is Eligible

Employee Eligibility


If you're an **active, regular full-time or regular part-time¹ employee**, you're eligible to participate in the Plan if you're:

- A U.S. citizen or resident alien employee working within or outside the U.S. (includes rotators and U.S. expats) who is paid on the direct U.S. dollar payroll²;
- A U.S. citizen or resident alien employee working within or outside the U.S. (includes rotators and U.S. expats) who is paid on the direct U.S. dollar payroll² and who is on a personal, disability or military leave of absence or on a family medical leave of absence or is an under-age-65 heritage Tosco former employee receiving long-term disability benefits with eligibility designated on Company records; or
- A non-citizen, non-resident alien employee working in the U.S. or on a personal or disability leave of absence or on a family medical leave of absence.

You're **not** eligible to participate in the Plan if your classification isn't described in this section. For example, temporary employees, intermittent employees, independent contractors, contingent workers, contract workers, leased employees and commission agents aren't eligible for the Plan.

Note: Special rules apply if your spouse is also a Company employee or retiree.

 *"If Your Eligible Spouse Is Also a Company Employee or Retiree," at right*

 Contact the Benefits Center for questions about whether your collective bargaining agreement expressly provides for your participation in the Plan.

 *"Contacts," page A-1*

If Your Eligible Spouse Is Also a Company Employee or Retiree

 Review the rules used in determining "spouse" eligibility.

 *"Dependent Eligibility," page I-4*

If both you and your eligible dependent spouse work or have worked for ConocoPhillips, you can be enrolled for coverage both as an employee or retiree and as a spouse. Retiree coverage does not include dependent life coverage for a spouse.

¹ Regular part-time employees must be regularly scheduled to work on average at least 20 hours per week.

² Direct U.S. dollar payroll means that payroll check is written in U.S. dollars by a U.S. company participating in the Plan and is not converted to another currency before being paid to the employee.

Dependent Eligibility

You can purchase dependent life coverage for your eligible dependents¹ (this provision is not available to an under-age-65 heritage Tosco former employee receiving long-term disability benefits with eligibility designated on Company records). Eligible dependents include your:

- Spouse (including your state-recognized common-law spouse²; excluding a spouse after a divorce or separation by a legal separation agreement); or your domestic partner; and
- Child³, as follows:
 - Your biological, legally adopted (includes foreign adoptions) or placed for adoption child;
 - Your domestic partner's biological or legally adopted child (includes foreign adoptions);
 - Your child under a legal guardianship agreement issued by a court; or
 - Your stepchild.

You can cover your child/stepchild/guardianship child/domestic partner's child if he or she is:

- Within the following age limits:
 - Under age 26⁴; or
 - Age 26 or older, provided the child was disabled prior to age 26 and coverage is approved by the Plan within 30 calendar days of his or her reaching age 26 or initial eligibility after age 26⁵.

¹ A dependent is not eligible if he or she:

- Is on active duty in the military service of any country (excluding weekend duty or summer encampment); or
- Is a stillborn child or is not yet born.

² The common-law marriage must be consummated in a state that recognizes common-law marriage, and all state requirements must have been met.

³ If you live in LA, MN, MT, NM or TX, state law currently has an expanded definition of "child," which may include grandchildren. Contact the Benefits Center if you live in one of these states and have a dependent who is not eligible per the above requirements but who might be eligible under your state's additional eligibility provisions.

⁴ Your child is considered an eligible dependent up to age 26 regardless of student status, marital status, employment status and/or IRS dependent requirements.

⁵ A disabled dependent over age 26 who is disabled prior to age 26 may also become an eligible dependent if such disabled dependent experiences a qualified change in status and becomes eligible for the Employee Medical Plan.

 "Contacts," page A-1

How to Enroll, Change or Cancel Coverage

- ✓ There are no enrollment requirements for basic life, travel assistance and OAD coverage. Coverage is automatic on the first date you meet the Plan's eligibility requirements. Coverage begins only if you're actively at work on that day. Otherwise, coverage will begin on the first date you are actively at work.

 "Employee Eligibility," page I-3

If you want to enroll in, change or cancel supplemental life coverage for yourself or dependent life coverage for all of your eligible dependents, you enroll online or call the Benefits Center. Your enrollment materials will contain information to help you make your enrollment elections. If you have questions about the enrollment procedure or need more information, contact the Benefits Center.

 "Contacts," page A-1

When you enroll, you'll:

- Choose from the Plan options available to you; and
- Authorize any required payroll deductions for the coverage you select.

When to Enroll, Change or Cancel Coverage

You can enroll, change or cancel your coverage at any time, but evidence of insurability (EOI) may be required or some limits may apply per the chart below.

If You Enroll/Change/Cancel Coverage ...	The Following Coverage Limits Apply ¹ ...	Evidence of Insurability (EOI) Is Required If ² ...	Your Coverage Is Effective ³ ...
Within 30 calendar days of your eligibility date (e.g., your hire date or the date you first become eligible to participate)	None	You elect supplemental life coverage equal to five, six, seven or eight times your <u>annual pay</u> ⁴	On your eligibility date, for coverage that doesn't require <u>EOI</u> . Coverage requiring <u>EOI</u> is effective on the later of the eligibility date or the first day of the month coincident with or following your enrollment and approval of any required <u>EOI</u> by the <u>Claims Administrator</u>
More than 30 calendar days after your eligibility date	You can enroll in the low option of dependent life coverage only	You elect any level of supplemental life coverage, unless you are changing from ConocoPhillips Group Variable Universal Life Plan for the same or lower amount of supplemental life coverage	On the first day of the month coincident with or following your enrollment and approval of any required <u>EOI</u> by the <u>Claims Administrator</u>
During annual enrollment	If you aren't on a <u>leave of absence</u> , you can increase your dependent life coverage by one level only (from no coverage to the low option, or from the low option to the high option) ⁵	You increase your supplemental life coverage level one or more levels	On the following Jan. 1 or the first day of the month coincident with or following your enrollment and approval of <u>EOI</u> by the <u>Claims Administrator</u> , whichever is later
Any other time during the year	You can increase your dependent life coverage by one level only (from no coverage to the low option, or from the low option to the high option) Only one increase in dependent life coverage is allowed per <u>plan year</u> (including any change elected during annual enrollment) ⁵	You increase your supplemental life coverage level one or more levels	On the first day of the month coincident with or following your enrollment and approval of any required <u>EOI</u> by the <u>Claims Administrator</u>
When you return to work as a regular full-time or regular part-time employee on or before expiration of a <u>leave of absence</u> , and you did not continue or you reduced coverage during leave	You can enroll in the low option of dependent life coverage only	You did not continue coverage, you elect any level of supplemental life coverage or you reduced coverage and want to increase coverage (not applicable if you're returning from a <u>family medical leave of absence (FMLA)</u> or a <u>military leave of absence</u> and enroll within 30 calendar days of your return to work)	On the first day of the month coincident with or following your enrollment and approval of any required <u>EOI</u> by the <u>Claims Administrator</u> . (If returning from a <u>family medical leave of absence (FMLA)</u> or a <u>military leave of absence</u> , coverage begins on your eligibility date if you enroll within 30 calendar days of your return to work.)

Please see the footnotes on the following page.

(continued)

If You Enroll/Change/Cancel Coverage ...	The Following Coverage Limits Apply ¹ ...	Evidence of Insurability (EOI) Is Required If ² ...	Your Coverage Is Effective ³ ...
Cancel or decrease any coverage	None	Not applicable	Until the last day of the month in which the request is received
When you acquire <u>eligible dependent(s)</u> Note: No action is required if you already have dependent coverage and add a new dependent to that coverage	<ul style="list-style-type: none"> If you enroll within 30 calendar days after acquiring dependent(s), you can elect either the low or high option If you enroll more than 30 calendar days after acquiring dependent(s), you can elect only the low option 	Not applicable	<ul style="list-style-type: none"> If you enroll within 30 calendar days after acquiring dependent(s): On the day the dependent(s) become eligible If you enroll more than 30 calendar days after acquiring dependent(s): On the first day of the month coincident with or following your enrollment
When you return to work as a regular full-time or regular part-time employee from a <u>leave of absence</u> -Labor Dispute of 30 or less calendar days, your coverage prior to the leave will automatically be reinstated	None	None	On the day you return to work
When you return to work as a regular full-time or regular part-time employee from a <u>leave of absence</u> -Labor Dispute of more than 30 calendar days and you enroll within 30 calendar days of your return	You can enroll only in the dependent life coverage level you had prior to the <u>leave of absence</u>	Only on any increased coverage levels to the level you had prior to the <u>leave of absence</u>	On the day you return to work, for coverage that doesn't require <u>EOI</u> . Coverage requiring <u>EOI</u> is effective on the later of the eligibility date or the first day of the month coincident with or following your enrollment and approval of any required <u>EOI</u> by the <u>Claims Administrator</u>
When you return to work as a regular full-time or regular part-time employee from a <u>leave of absence</u> -Labor Dispute of more than 30 calendar days and you enroll more than 30 calendar days after your return	You can enroll only in low option of dependent life coverage level, even if you converted your coverage and had continuous coverage during your <u>leave of absence</u>	You elect any level of supplemental life coverage, even if you converted your coverage and had continuous coverage during your <u>leave of absence</u>	Supplemental and dependent life coverage begin on the first day of the month coincident with or following your enrollment and approval of any required <u>EOI</u> by the <u>Claims Administrator</u> . Occupational accidental death (OAD), travel assistance and basic life coverage begin on the eligibility date

¹ Unless stated otherwise in this column, you can enroll in any of the Plan's supplemental and/or dependent life coverage options, subject to EOI requirements in the next column. If the Company rehires you within two years of when your employment ended and you still have ported or converted coverage from the Claims Administrator, your active employee coverage will not be effective unless you surrender that coverage.

² If EOI is due to late enrollment, any expenses will be paid by the participant.

³ Basic, travel assistance and OAD coverage begin on the first day that you meet the Plan's eligibility requirements.

⁴ If you were an employee from COG Operating LLC on Jan. 1, 2022, during annual enrollment for 2022 you could elect an amount of supplemental life insurance comparable to the amount of life insurance you had on Dec. 31, 2021 without providing EOI. Any additional elections were subject to Plan rules for EOI.

⁵ You cannot increase coverage while you are on a leave of absence.

For all of the dates shown in the chart on the previous page, coverage begins only if you're actively at work on that day. Otherwise, coverage will begin on the first date you are actively at work.

If you have enrolled in dependent coverage and the individual dependent is hospitalized, receiving or applying to receive disability benefits from any source or is confined at home under a physician's care on the date his or her coverage would normally begin, such coverage will be delayed until the first day he or she is no longer meeting any of these provisions.

If You Take a Leave of Absence

If you're on a leave of absence, you may continue coverage for yourself and your dependents during the approved leave period — provided you make any required payments for coverage when they're due.

- Basic life and travel assistance coverage for you continues as a Company-paid benefit. OAD coverage is suspended until you return to work.
- During your leave, you pay the same cost for coverage that an active employee would pay for supplemental life coverage and dependent life coverage.
 - If you're on a paid leave, your monthly costs will continue to be deducted from your paycheck on an after-tax basis.
 - If you're not receiving a paycheck from the Company, you'll pay the cost for coverage to ConocoPhillips on an after-tax basis. (ConocoPhillips will bill you monthly during the leave for the cost for coverage.)
- If coverage continued during your leave of absence, when you return to work the Company will resume deducting the coverage cost from your paycheck on an after-tax basis. OAD coverage resumes when you return to work.

If you end your supplemental or dependent life coverage while you're away on leave — or if your coverage is ended due to non-payment of required costs — you must meet the same enrollment criteria as an active employee if you want to re-enroll in the Plan upon your return to work (not applicable if you're returning from a family medical leave of absence (FMLA) or a military leave of absence and enroll within 30 calendar days of your return to work).



"Who Is Eligible," page I-3; "How to Enroll, Change or Cancel Coverage," page I-4

✓ If You're on a Military Leave of Absence

Your OAD coverage will be suspended during your military leave of absence and will resume upon your return to work as an active employee.

If You Have a Leave of Absence-Labor Dispute

If you're placed on a leave of absence-Labor Dispute, your basic, travel assistance, supplemental and dependent coverage will end on the last day of the month in which the leave begins. Your occupational accidental death coverage will end on the day before your leave begins. You may continue coverage for yourself and your dependents (excluding OAD and travel assistance coverage) during the leave under continuation provisions. If you're eligible for retiree life, you may elect that coverage. See the chart on page I-6 for coverage after you return to work. If you are on a leave of absence-Labor Dispute during a regularly scheduled annual enrollment, you will not be eligible and a special annual enrollment period will be provided after you return from the leave of absence-Labor Dispute.

What the Plan Costs

ConocoPhillips pays the full cost of your basic life, travel assistance and OAD coverage.

You pay the entire cost of your supplemental and dependent life coverage with after-tax dollars deducted from your pay each month.



- The cost of supplemental life coverage is based on your age and coverage amount. If a birthday moves you to a different coverage age-group rate, the new rate is effective the first of the month coincident with or following your birthday. If your salary increases or decreases during the year, your coverage amount will change on the first of the month coincident with or following your salary increase/decrease.
- The cost of supplemental and dependent life coverage may change from year to year. When you enroll, you will receive information about how to access the current costs.

The Benefits Committee reserves the right to recover any underpayments by the employee or eligible dependent, made through error or otherwise, by offsetting future payments, invoicing the affected participant, or by other means as the Benefits Committee deems appropriate.

✓ If you were an employee of Tosco Corporation or any of its subsidiaries who adopted their life insurance plan prior to Jan. 1, 2003 and were approved for long-term disability benefits, life insurance premiums were waived with the insurer, subject to all the terms and provisions of the life insurance policy.

How the Employee Life Plan Works

The Group Life Plan includes the coverage amounts shown below. **Note:** Supplemental and dependent life coverages are not available to under-age-65 heritage Tosco former employees receiving long-term disability benefits with eligibility designated on Company records.

Coverage Type	Benefit Amount
Basic Life (Company provided)	<ul style="list-style-type: none"> One times <u>annual pay</u>, rounded to the next higher \$100, up to a maximum benefit of \$3 million
Supplemental Life (Optional, employee-paid coverage) Not available if you have an individual policy under the ConocoPhillips Group Variable Universal Life Plan	<ul style="list-style-type: none"> One, two, three, four, five, six, seven or eight times your <u>annual pay</u>, rounded to the next higher \$100, up to a maximum benefit of \$14 million
Dependent Life (Optional, employee-paid coverage)  "Dependent Life," page I-10	<ul style="list-style-type: none"> High option: \$75,000 coverage for your spouse and \$25,000 coverage for each of your <u>eligible dependent</u> children Low option: \$40,000 coverage for your spouse and \$15,000 coverage for each of your <u>eligible dependent</u> children
Occupational Accidental Death (OAD) Coverage (Company provided)  "Occupational Accidental Death (OAD) Coverage," page I-11	<ul style="list-style-type: none"> \$500,000 (The benefit is taxable income, is not grossed up for taxes and is not subject to interest for the time between death and the payment date.)

✓ Imputed Income

By law, the value of Company-paid group life in excess of \$50,000 is included in your taxable income for the year. This value, known as "imputed income," is calculated according to IRS tables and is reported as income on your annual W-2 form and on your paychecks throughout the year. Also by law, the total cost of dependent life is included in your taxable income as "imputed income" for the year.

Accelerated Benefit Option

✓ This option is not available if you have assigned your Plan benefits.

The Plan's accelerated benefit option protects you and your family from financial loss if you're suffering from a terminal illness. This option enables you to receive an immediate lump-sum payment of up to 80% of your basic life and/or supplemental life coverage if you're diagnosed as terminally ill with 24 months or less to live and have at least \$10,000 of total coverage. If you elect this option:

- The minimum payout is \$8,000.
- The maximum payout is 80% of your total life coverage, up to a maximum of \$1,000,000.

You can also receive an immediate lump-sum payment of up to 80% of your dependent life coverage if your covered spouse is diagnosed as terminally ill with 24 months or less to live. If you elect this option, the maximum payout is \$60,000. The accelerated benefit option is not available for a dependent child.

The accelerated benefit is payable only once. You'll continue to make payments for the full amount of coverage as long as you are covered as an active employee.


To apply for accelerated benefits, contact the Benefits Center. The appropriate paperwork will be forwarded to you for you and your physician to complete and return. The Claims Administrator will determine if you're approved to receive accelerated benefits and may require you or your dependent to be examined by a physician of their choice at their expense. Payment, if approved, will be made in a lump sum as soon as administratively practicable.

 "Contacts," page A-1

Dependent Life

Dependent life coverage is offered to protect you from financial hardship if a covered eligible dependent dies. Additional information about dependent life coverage is provided as follows:

- Your spouse and children are covered by the same dependent life option; you choose one option that covers your spouse and your children.
- If both you and your spouse or former spouse are Company employees, you may each elect dependent life coverage for your children and spouse.
- When you enroll in dependent life coverage, all of your eligible dependents are covered automatically as long as you pay the costs. If you gain or lose an eligible dependent, you don't need to contact the Plan to update your information. (However, you should contact the Benefits Center so you can make changes to your other ConocoPhillips benefit elections.) **Note:** You will want to contact the Benefits Center if you change from having no dependents to having dependent(s) or vice versa.

 "How to Enroll, Change or Cancel Coverage," page I-4;
"Contacts," page A-1

Occupational Accidental Death (OAD) Coverage

Company-provided OAD coverage pays a benefit if you die as a direct result of a bodily injury caused by a covered occupational accident, provided:

- You were eligible for coverage when the occupational accident occurred;
- The occupational accident is the sole cause of the bodily injury;
- The bodily injury, independent of all other causes, is the sole cause of death; and
- Death occurs within 90 days after the date of the occupational accident.

When OAD Benefits Are Not Paid

OAD benefits will not be paid for any death which directly or indirectly, in whole or in part, is caused by or results from one or more of the conditions, events or situations described below. A condition, event or situation is considered to have caused or contributed to the death if it caused or contributed to the accident, the injury or the death. The Benefits Committee has discretion to decide if any postmortem tests or investigations are required prior to denying or paying an OAD benefit.

- Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, including exposure, whether or not accidental, to viral, bacterial or chemical agents; except for any bacterial infection resulting from an external cut or wound that was sustained in an occupational accident or accidental ingestion of contaminated food;
- Suicide or attempted suicide, whether sane or insane;
- Injuring oneself on purpose;
- Voluntary use or consumption of any poison, chemical compound or drug (recreational, illegal or prescribed);
- Any overdose or adverse reaction to a prescribed medication used to treat a physical or mental condition;
- Involvement in a riotous activity or fight that you initiated;
- Injury sustained while committing or attempting to commit a felony;

- Operating a land, water or air vehicle while legally intoxicated as defined by the laws of the jurisdiction in which the vehicle was being operated;
- Violation of a state or federal law;
- Violation of Company safety rules or operating procedures;
- A nonoccupational accident;
- Presence on Company property as a member of the general public rather than as an employee;
- Voluntary participation in a wellness program or in a medical, fitness or recreational activity such as blood donation, physical examination, flu shot, exercise class, basketball, volleyball and other exercise activities;
- Eating, drinking or preparing food or drink for personal consumption (whether bought on Company premises or brought in);
- Choking on a non-food-related product;
- Performance of personal tasks (unrelated to job responsibilities and the accident was not a result of Company negligence); or
- Operating a vehicle or walking or otherwise moving on a Company parking lot, Company access road or Company sidewalk or walkway while arriving at or leaving the work site.

Travel Assistance Coverage

Travel assistance coverage provides pre-trip information, emergency medical assistance, identity theft assistance and emergency personal services, 24 hours a day, 365 days a year worldwide for you, your spouse (or domestic partner) and dependent children under the age of 26, even if not enrolled in this Plan's dependent life (see the "Dependent Eligibility" section of group life for dependent eligibility criteria), when you have an emergency on a covered trip (excluding identity theft assistance). Travel assistance services — which are available only when specific Plan criteria are met — are shown at right. You or your health insurance is responsible for incurred medical expenses, just as if you were at home. You are responsible for the cost of air fare not approved as medically necessary by the attending physician; food, hotel and car expenses; and attorney fees. Emergency cash advances and bail advancement require your personal satisfactory guarantee of reimbursement provided through a valid credit card. Contact the travel assistance Claims Administrator for more information.

 "Contacts," page A-1; "Dependent Eligibility," page I-4

For all of the services listed here, the travel assistance Claims Administrator must be contacted at the time of need and the service or expense approved in advance in order for coverage to apply.

It is your responsibility to inquire, prior to departure, whether assistance services are available in the countries where you are traveling due to possible political situations. Travel assistance services arranged and provided by the Claims Administrator are subject to a limit of \$1 million (combined single limit) to the insured.

- Pre-Trip Information:
 - Visa and passport requirements.
 - Inoculation and immunization requirements.
 - Foreign exchange rates.
 - Embassy and consular referrals.
- Emergency Medical Assistance:
 - Medical referrals.
 - Medical monitoring.
 - Medical evacuation.
 - Repatriation.
 - Traveling companion assistance.
 - Dependent children assistance.
 - Visit by a family member or friend.
 - Emergency medical payments.
 - Return of mortal remains.
- Emergency Personal Services:
 - Medication and eyeglass assistance.
 - Emergency travel arrangements.
 - Emergency cash.
 - Locating lost items.
 - Bail advancement.
- Identity Theft Assistance (whether traveling or at home):
 - Prevention services (education and identity theft resolution kit).
 - Detection services (fraud alert to three credit bureaus).
 - Resolution guidance and assistance (credit information review, ID theft affidavit assistance, card replacement).
 - Personal services (translation and emergency cash advance in certain circumstances).

Travel Assistance Coverage Exclusions and Limitations

The Plan will not provide services or pay for expenses caused by or resulting from:

- Traveling to seek medical treatment;
- Suicide or attempted suicide;
- Intentionally self-inflicted injuries;
- Participation in any war, invasion, acts of foreign enemies, hostilities between nations (whether declared or not) or civil war, rebellion, revolution, and insurrection, military or usurped power;
- Participation in any military maneuver or training exercise;
- Traveling against the advice of a physician;
- Piloting or learning to pilot or acting as a member of the crew of any aircraft;
- Mental or emotional disorders, unless hospitalized;
- Being under the influence of drugs or intoxicants, unless prescribed by a physician;
- Commission of or the attempt to commit a criminal act;
- Participation as a professional in athletics or underwater activities;
- Participating in bodily contact sports: skydiving, hang gliding, parachuting, mountaineering, any race, bungee cord jumping, speed contests, spelunking or caving, heli-skiing, or extreme skiing;
- Dental treatment except as a result of accidental injury to sound, natural teeth;
- Any non-emergency treatment or surgery, routine physical examinations, hearing aids, eyeglasses or contact lenses;
- Pregnancy or childbirth (except for complications of pregnancy);
- Curtailment or delayed return for other than covered reasons.

How Benefits Are Paid

The Group Life Plan will pay benefits as follows:

- **Basic and supplemental life:** The Plan will pay benefits to your designated beneficiary(ies). The benefit amount is based on your annual pay at the time of your death.
- **Dependent life:** The Plan will pay benefits to you.
- **OAD:** The Plan will pay benefits to your designated beneficiary(ies). The benefit is taxable income, is not grossed up for taxes and is not subject to interest for time between death and payment date.



"Naming or Changing Your Beneficiary," page I-14

Benefits will be paid as soon as the Claims Administrator receives proof supporting the claim.

Note: Once a claim has been filed, the Claims Administrator may have an autopsy performed at its own expense, provided it's not against local law. Benefits will not be paid while a beneficiary is under suspicion of murdering the covered person. No payment will be made to a beneficiary convicted of murdering the covered person.

The Claims Administrator may pay Plan benefits to a beneficiary in a lump sum or in an account which is similar to a checking account. The account method is not used for OAD benefit payments. The account is for withdrawals only; no additional funds can be deposited into it. Your beneficiary can write a check to move the money elsewhere or can leave the money in the account to earn interest.

Any payment made under this Plan for basic and/or supplemental life, dependent life and/or OAD benefits will discharge the Claims Administrator's liability for the amount paid.

Naming or Changing Your Beneficiary

You must name a beneficiary (the person or persons designated to receive Plan benefits in the event of your death). You may name as many beneficiaries as you wish — including individual persons, your estate, a trust, church or charitable organizations.

- You're the designated beneficiary of your dependent life benefits. You cannot name someone else as beneficiary, and you cannot name a contingent beneficiary. If you and your dependent(s) die within the same 24-hour period, the dependent life benefits will be paid as described under "If You Don't Have a Beneficiary."

 "If You Don't Have a Beneficiary," page I-14

- If you designate more than one beneficiary without identifying their respective shares, the beneficiaries will share equally.
- When designating your beneficiary, provide the Social Security number and as much information as possible (e.g., full name, date of birth, current address).
- By law, benefits cannot be paid directly to a minor (anyone under 18 years old) or a legally incompetent person — benefits will be paid to the court-appointed guardian. In the absence of a court-appointed guardian, the Claims Administrator will hold the proceeds until the minor reaches age 18.
- If your marriage status changes (divorce, re-marriage, etc.), you may wish to make a new valid beneficiary designation. Advising the Company of your status change does **not** change your beneficiary designation. You must make a new beneficiary designation if you want to make changes to your existing designation.
If you named your spouse as your beneficiary prior to your divorce, your divorce does not automatically revoke your election and your ex-spouse will remain your beneficiary until you change your beneficiary designation.
- Unless you specify otherwise, the interest of any beneficiary who dies before you, at the same time as you, or within 24 hours of your death, will be paid as described under "If You Don't Have a Beneficiary."

 "If You Don't Have a Beneficiary," at right

- From time to time, you may be required to make a new valid beneficiary designation for the purpose of administration of the Plan.

You can name or change your beneficiary designation at any time. Your beneficiary designation must be submitted online at <http://hr.conocophillips.com/contacts-resources/mybenefits> or by calling the Benefits Center. A beneficiary designation by any other means will not be accepted. Your valid beneficiary designation is effective on the date you (or the owner of your coverage, if you had assigned your coverage prior to Jan. 1, 2006) make the designation.

If You Don't Have a Beneficiary

Plan benefits will be paid according to the provisions shown below if:

- You didn't designate a beneficiary;
- Your designated primary and contingent beneficiaries die before you, at the same time as you, or within 24 hours of your death; or
- For dependent life benefits, your dependent dies at the same time as you or within 24 hours of your death.

The provisions state that the Claims Administrator may pay all or part of the benefits due in the following order:

- Your spouse, if alive;
- Your child(ren), if there is no surviving spouse;
- Your parent(s), if there is no surviving child;
- Your sibling(s), if there is no surviving parent; or
- Your estate, if there is no surviving sibling.

Any payments made will relieve the Claims Administrator of any liability for the Plan benefits.

How to File a Claim

To initially file a claim under the Group Life Plan, you, a family member or a beneficiary should contact the Benefits Center. The following information will need to be provided:

 “Contacts,” page A-1

- The deceased’s name;
- The deceased’s Social Security number;
- The date of death; and
- Information regarding spouse or next of kin:
 - Name;
 - Address;
 - Phone number; and
 - Relationship to the deceased.

To file a claim for Travel Assistance Services, contact the Claims Administrator when services are needed.

 “Contacts,” page A-1

Claims must be received by the Benefits Center within 30 days after the date of death or as soon as reasonably possible. Proof of loss should be submitted within 90 days of when it is due.

A certified death certificate must be provided before any benefits can be paid. Other documents (for example, a copy of trust or estate documents) may also be required, depending on your beneficiary designations. The claimant will be advised if additional documents are needed to support a claim.

When a claim is filed with the Plan, the claimant is consenting to the release of information to the Claims Administrator and granting certain rights to the Claims Administrator.

 “Information and Consents Required From You,” page N-31

Claim Review and Appeal Procedure

For information about when to expect a response to your claim from the Claims Administrator and/or Appeals Administrator or how to file an appeal if your claim is denied, refer to the “Claims and Appeals Procedures” section.

 “Claims and Appeals Procedures,” page N-26



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- ✓ The Benefits Center is the initial point of contact for all notice of claim submissions under the Group Life Plan. Send your completed claims and supporting documentation to the address shown in the claim packet. Certificates of insurance are not issued and aren’t required in order to file a claim.

 “Contacts,” page A-1


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- ✓ Questions about benefit claims should be directed first to the representative handling your claim, who may direct you to the Claims Administrator. The Claims Administrator approves or denies claims based on the applicable terms of the Plan documents, including the insurance contract.

 “Contacts,” page A-1

When Coverage Ends

- ✓ If your Group Life coverage ends, you may be eligible to continue coverage as follows:
- Through portability or conversion to an individual policy; or
 “Continuation of Coverage,” at right
 - Through Group Retiree Life coverage.
 Refer to the separate **Retiree Benefits Handbook** available from the Benefits Center or on hr.conocophillips.com.

Your basic life, travel assistance, supplemental life and/or OAD coverage will end on the earliest of the following events:

- The last day of the month in which your employment ends for any reason (the coverage termination date is designated with Plan eligibility on Company records for heritage Tosco former employees receiving long-term disability benefits). **Note:** OAD coverage ends on your termination date;
- The last day of the month in which you no longer meet the Plan’s eligibility requirements;
 “Employee Eligibility,” page I-3
- The last day of the month in which you don’t pay the required costs for supplemental life coverage;
- The last day of the month in which your supplemental coverage is terminated for any other reason not stated in this section. **Note:** Coverage under that option only is terminated;
- The last day of the month in which your leave of absence-Labor Dispute begins. **Note:** OAD coverage ends on the day before your leave of absence-Labor Dispute begins;
- The date of your death for basic life, travel assistance, supplemental life and OAD coverage;
- The date on which the Company terminates relevant coverage (basic life, supplemental life and/or OAD coverage); or
- The date on which the Group Life Plan is terminated.

Coverage for your covered dependents ends on the earliest of the following events:

- The last day of the month in which your basic coverage ends;
- The last day of the month in which your dependent no longer qualifies as an eligible dependent as defined by the Plan;
- The last day of the month in which coverage for your dependent(s) is terminated for any other reason not stated in this section;
- The last day of the month in which you don’t pay the required costs for dependent life coverage;
- The last day of the month in which your dependent becomes eligible for coverage as a Company employee;
- The date of your dependent’s death; or
- The date on which the Company terminates dependent life coverage.

Continuation of Coverage

Contact the Claims Administrator to determine if you and/or your covered dependents are eligible for portability or conversion provisions of your life coverage as offered by the insurer.

Continuation of coverage is not available for OAD or travel assistance coverage.

Some rules apply to group life continuation of coverage:

- The participant must apply for continuation of coverage within the allowed days specified on the application that he or she will receive. **Note: The option of continuation of coverage is never available beyond 91 days from your coverage termination date.**
- Your continuation of coverage cannot exceed the coverage you had prior to termination of coverage or Plan limits.
- Your continuation of coverage will become effective on the date after which your Company group coverage ends.

- If you or a covered dependent die(s) within the 31-day continuation-election period, the amount of coverage you had prior to the date of coverage termination will be paid to you or your beneficiary(ies).
- The participant will be billed monthly by the insurer.

✓ For information about continuation of coverage options, contact the Claims Administrator's office that administers portability and conversion.

 "Contacts," page A-1

Employee Accidental Death and Dismemberment Plan

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✓ Please refer to the Glossary beginning on page O-1 for the definitions of underlined terms used throughout this SPD.

📖 “Glossary,” page O-1

In this chapter, the term “Company” refers to ConocoPhillips and the other companies that have adopted this Plan.

Introduction

The ConocoPhillips Group Life Plan (the Plan) offers accidental death and dismemberment (AD&D) benefits that provide your family with valuable financial protection in the event of your death, dismemberment or other covered loss due to a covered accident. This coverage is in addition to any basic, supplemental, travel assistance and dependent life and occupational accidental death (OAD) insurance available under other provisions of the Group Life Plan.

📖 “Employee Life Plan,” page I-1



Who Is Eligible

Employee Eligibility


If you're an **active, regular full-time or regular part-time¹ employee**, you're eligible to participate in the Plan if you're:

- A U.S. citizen or resident alien employee working within or outside the U.S. (includes rotators and U.S. expats) who is paid on the direct U.S. dollar payroll²;
- A U.S. citizen or resident alien employee working within or outside the U.S. (includes rotators and U.S. expats) who is paid on the direct U.S. dollar payroll² and who is on a personal, disability or military leave of absence or on a family medical leave of absence; or
- A non-citizen, non-resident alien employee working in the U.S. or on a personal or disability leave of absence or on a family medical leave of absence.

You're **not** eligible to participate in the Plan if your classification isn't described in this section. For example, temporary employees, intermittent employees, independent contractors, contingent workers, contract workers, leased employees and commission agents aren't eligible for the Plan.

Note: Special rules apply if your spouse is also a Company employee.

 *"If Your Eligible Spouse Is Also a Company Employee," at right*


 Contact the Benefits Center for questions about whether your collective bargaining agreement expressly provides for your participation in the Plan.

 *"Contacts," page A-1*

¹ Regular part-time employees must be regularly scheduled to work on average at least 20 hours per week.

² Direct U.S. dollar payroll means that payroll check is written in U.S. dollars by a U.S. company participating in the Plan and is not converted to another currency before being paid to the employee.

If Your Eligible Spouse Is Also a Company Employee

 Review the rules used in determining "spouse" eligibility.

 *"Dependent Eligibility," page J-4*

If both you and your eligible dependent spouse work and are enrolled in AD&D, you can be enrolled for coverage both as an employee and as a spouse of an employee. However, limits apply to the total amount of coverage you can elect for yourselves and for your covered dependent children. See "How the Plan Works" for details.

 *"How the AD&D Plan Works," page J-7*

Dependent Eligibility

You can purchase dependent AD&D coverage for your eligible dependents¹. Eligible dependents include your:

- Spouse (including your state-recognized common-law spouse²; excluding a spouse after a divorce or separation by a legal separation agreement); or your domestic partner; and
- Child³, as follows:
 - Your biological, legally adopted (includes foreign adoptions) or placed for adoption child;
 - Your domestic partner's biological or legally adopted child (includes foreign adoptions);
 - Your child under a legal guardianship agreement issued by a court; or
 - Your stepchild.

You can cover your child/stepchild/guardianship child/domestic partner's child if he or she is:

- Within the following age limits:
 - Under age 26⁴; or
 - Age 26 or older, provided the child was disabled prior to age 26 and coverage is approved by the Plan within 30 calendar days of his or her reaching age 26 or initial eligibility after age 26⁵.

¹ A dependent is not eligible if he or she:

- Is on active duty in the military service of any country (excluding weekend duty or summer encampment); or
- Is a stillborn child or is not yet born.

² The common-law marriage must be consummated in a state that recognizes common-law marriage, and all state requirements must have been met.

³ If you live in LA, MN, MT, NM or TX, state law currently has an expanded definition of "child," which may include grandchildren. Contact the Benefits Center if you live in one of these states and have a dependent who is not eligible per the above requirements but who might be eligible under your state's additional eligibility provisions.

⁴ Your child is considered an eligible dependent up to age 26 regardless of student status, marital status, employment status and/or IRS dependent requirements.

⁵ A disabled dependent over age 26 who is disabled prior to age 26 may also become an eligible dependent if such disabled dependent experiences a qualified change in status and becomes eligible for the Employee Medical Plan.

 "Contacts," page A-1

How to Enroll, Change or Cancel Coverage

If you want to enroll in, change or cancel AD&D coverage for yourself or for your eligible dependents, you enroll online or call the Benefits Center. Your enrollment materials will contain information to help you make your enrollment elections. If you have questions about the enrollment procedure or need more information, contact the Benefits Center.

 "Contacts," page A-1

When you enroll, you'll:

- Choose from the AD&D options available to you;
- Decide which of your eligible dependents (spouse and/or dependent children) you wish to cover, if any; and
- Authorize any required payroll deduction for the cost of the coverage you select.

When to Enroll, Change or Cancel Coverage

You can enroll, change or cancel AD&D coverage at any time. Evidence of insurability (EOI) is not required.

When Coverage Begins

The date coverage for you and/or your eligible dependents begins depends on when you enroll.

If you enroll or change your coverage:	Coverage is effective:
Within 30 calendar days of your eligibility date (e.g., your hire date or the date you first become eligible to participate)	On your eligibility date
More than 30 calendar days after your eligibility date	On the first day of the month coincident with or following your enrollment
During annual enrollment ¹	On the following Jan. 1
Any other time during the year ¹	On the first day of the month coincident with or following your enrollment
When you return to work as a regular full-time or regular part-time employee on or before expiration of a <u>leave of absence</u> and did not continue insurance during leave	<ul style="list-style-type: none"> • If you re-enroll WITHIN 30 calendar days of your return to work: On the day you return to work • If you re-enroll MORE THAN 30 calendar days after your return to work: On the first day of the month coincident with or following your enrollment
When you acquire a spouse or your first dependent child for dependent coverage ¹	<ul style="list-style-type: none"> • If you enroll WITHIN 30 calendar days after acquiring the new dependent: On the date you acquired the new dependent • If you enroll MORE THAN 30 calendar days after acquiring the new dependent: On the first day of the month coincident with or following your enrollment
When you return to work as a regular full-time or regular part-time employee from a <u>leave of absence</u> -Labor Dispute of 30 or less calendar days, your coverage prior to the leave will automatically be reinstated	On your eligibility date
When you return to work as a regular full-time or regular part-time employee from a <u>leave of absence</u> -Labor Dispute of more than 30 calendar days	<ul style="list-style-type: none"> • If you enroll WITHIN 30 calendar days of your eligibility date: On your eligibility date • If you enroll MORE THAN 30 calendar days following your eligibility date: On the first day of the month coincident with or following your enrollment

¹ You cannot increase coverage while you are on a leave of absence.

For all of the dates shown in the chart above, coverage (or a coverage change) begins for you and any enrolled dependents only if you're actively at work on that day. Otherwise, coverage will begin on the first date you're actively at work.

Changing Your Coverage

You can enroll in the AD&D Plan, or change or cancel your Plan elections at any time.


- Coverage changes will be effective on the first of the month coincident with or following your enrollment.
- Once you're enrolled in the Plan, increases or decreases in your coverage amount can be made in \$10,000 increments.

If You Take a Leave of Absence

If you're on a leave of absence, you may continue coverage for yourself and your dependents during the approved leave period — provided you make any required payments for coverage when they're due.

- During your leave, you pay the same cost for coverage that an active employee would pay for individual and/or dependent AD&D coverage.
 - If you're on a paid leave, your monthly costs will continue to be deducted from your paycheck on an after-tax basis.
 - If you're not receiving a paycheck from the Company, you'll pay the cost for coverage to ConocoPhillips on an after-tax basis. (ConocoPhillips will bill you for the cost for coverage.)
- If coverage continued during your leave of absence, when you return to work the Company will resume deducting the coverage cost from your paycheck on an after-tax basis.

If you end your coverage while you're away on leave — or if your coverage is ended due to non-payment of required costs — you must meet the same enrollment criteria as an active employee if you want to re-enroll in the Plan upon your return to work.

 “Who Is Eligible,” page J-3; “How to Enroll, Change or Cancel Coverage,” page J-4

If You Have a Leave of Absence-Labor Dispute

If you're placed on a leave of absence-Labor Dispute, coverage for you and your dependents will end on the last day of the month in which the leave begins. You may continue coverage for yourself and your dependents during the leave under continuation provisions. See the chart on page J-5 for coverage after you return to work. If you are on a leave of absence-Labor Dispute during a regularly scheduled annual enrollment, you won't be eligible and a special annual enrollment period will be provided after you return from the leave of absence-Labor Dispute.

What the Plan Costs

You pay the entire cost of your AD&D coverage with after-tax dollars deducted from your pay each month. The cost of AD&D coverage may change from year to year. The price for coverage for dependent children is the same, regardless of the number of children covered. When you enroll, you'll receive information about how to access the current costs.

The Benefits Committee reserves the right to recover any underpayments by the employee or eligible dependent made through error or otherwise, by offsetting future payments, invoicing the affected participant, or by other means as the Benefits Committee deems appropriate.

How the AD&D Plan Works

Accidental Death and Dismemberment Benefits

When you enroll in the Plan, you can elect AD&D coverage for yourself and your eligible dependents (spouse and/or dependent children). The amount of coverage you elect — the principal sum — is paid if you or your spouse or dependent child dies as a result of a covered accidental injury. A percentage of the principal sum is paid for certain other covered losses. Coverage is subject to the limits and restrictions shown below.

- Coverage for yourself can be purchased in multiples of \$10,000, starting at \$20,000 up to a maximum of \$1 million or 12 times your annual pay (rounded up to the next \$10,000 increment), whichever is less.
- Coverage for your spouse can be purchased in multiples of \$10,000 starting at \$20,000 up to a maximum of \$500,000 or the amount of your coverage, whichever is less.
- Coverage for your dependent children can be purchased in multiples of \$10,000, starting at \$10,000, up to a maximum of \$50,000 or the amount of your coverage, whichever is less. Each of your dependent children will be covered for the amount elected.
- If both you and your spouse work and are enrolled in AD&D, you can enroll for coverage both as an employee and as a spouse. However:
 - The combined maximum amounts of coverage cannot exceed \$1 million per covered person; and
 - The combined maximum for each of your child(ren) cannot exceed \$50,000. (For example, if you purchased \$30,000 coverage for each of your children, your spouse could purchase a maximum of \$20,000 coverage for them.)

The following table shows the percentage of the total benefit amount that you and/or your covered dependents would receive in the event of death or severe injury resulting from a covered accident.

For the following covered loss ¹ ...	The Plan pays this portion of your total principal sum ² ...
Life	100%
Hand or foot	50%
Arm or leg	75%
Sight in one eye	50%
Both hands or both feet or sight in both eyes	100%
Either hand or foot and sight in one eye	100%
Any combination of hand, foot or sight in one eye	100%
Thumb and index finger of same hand	25%
Speech and hearing in both ears	100%
Speech or hearing in both ears	50%
Paralysis ³ of both upper and lower limbs (quadriplegia)	200%
Paralysis ³ of both lower limbs (paraplegia)	75%
Paralysis ³ of one arm and both legs or both arms and one leg	100%
Paralysis ³ of the upper and lower limbs of one side of the body (hemiplegia)	66%
Paralysis ³ of one limb (uniplegia)	50%
Brain damage ⁴	100%
Coma ⁵	1% of the <u>principal sum</u> monthly beginning on the 31st day of the coma for the duration of 12 months.

¹ "Loss" means:

- **Loss of sight** means the entire and irrevocable loss thereof.
- **Loss of thumb and index finger of same hand** means that the thumb and index finger are severed through or above the metacarpophalangeal joints.
- **Loss of speech** means the entire and irrecoverable loss of speech thereof.
- **Loss of hearing** means the entire and irrecoverable loss thereof.

² In the event of a covered accident, no more than the principal sum will be paid as a result of a single accident with multiple losses.

³ **Paralysis** means loss of use of a limb, without severance. A physician must determine the paralysis to be complete and irreversible.

⁴ **Brain damage** means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities of a person of like age and gender in good health. Such damage must manifest itself within 30 days of the covered accident, require a hospitalization of at least five days and persist for 12 consecutive months after the date of the accidental injury.

⁵ **Coma** means complete and continuous unconsciousness and inability to respond to external or internal stimuli as verified by a physician. Such state must begin within 31 days of the covered accident and continue for 31 consecutive days.

The loss must be the direct result and independent of other causes of the covered accident and must be incurred within 12 months after the accident, unless designated otherwise.

- ✓ The covered person will be presumed to have died as a result of a covered accident if the aircraft or other vehicle operated by a common carrier in which they were traveling disappears, sinks or is wrecked and the body of the person isn't found within one year of the scheduled destination arrival or the date the person is reported missing to the authorities.


A loss will be deemed as the direct result of a covered accident if it results from unavoidable exposure to the elements and such exposure was a direct result of the covered accident.

- ✓ Acts of war, whether declared or undeclared, will be covered with the exception of in the United States.

 "Contacts," page A-1

Other Benefits

If AD&D benefits are paid as the result of a covered accident, the following benefits may also apply:

AD&D Benefit	Description
Common Disaster <i>Available if you and your covered spouse die within 90 days as the result of the same <u>covered accident</u></i>	Your spouse's AD&D benefit amount will be increased to equal the full amount payable for your loss of life.
Child Education <i>Available if you or your covered spouse die as a result of <u>injuries</u> suffered in a <u>covered accident</u></i>	<ul style="list-style-type: none"> The child education AD&D benefit for each covered child is the lesser of actual costs or an annual amount equal to 20% of your or your spouse's <u>principal sum</u>, up to a maximum AD&D benefit of \$25,000 per year. The minimum benefit is \$2,500. The AD&D benefit may be paid annually for four consecutive years, provided your covered child continues his or her education. Only one AD&D benefit per school year is allowed per covered child. The AD&D benefit is payable to each covered child who, on the date of the death, was either: <ul style="list-style-type: none"> Enrolled as a full-time post-high school student in an accredited institution of learning; or Enrolls as a full-time post-high school student in an accredited institution of learning within 365 days after the date of the death and was a student in the 12th grade on the date of the death. Before the AD&D benefit is paid each year, the covered child may be required to present written proof to the <u>Claims Administrator</u> that he or she is attending an institution of learning on a full-time basis. If you and your covered spouse die simultaneously, AD&D benefits under this provision will not exceed the overall maximum applied to the combined total of your and your spouse's <u>principal sums</u>. If there are no dependent children who qualify for this AD&D benefit, an additional AD&D benefit of \$2,500 will be paid to your designated <u>beneficiary</u>. <p> "Naming or Changing Your Beneficiary," page J-11</p>

(continued)

AD&D Benefit	Description
<p>Seat Belt and Air Bag Benefit (Includes Child Restraint Device)</p> <p><i>Available if you or your covered dependent are injured or die as a result of an automobile accident and the conditions in the next column were met</i></p>	<ul style="list-style-type: none"> The <u>seat belt</u> and <u>air bag</u> AD&D benefits are each equal to 10% of the covered person's <u>principal sum</u>, up to a maximum AD&D benefit of \$25,000 and a minimum AD&D benefit of \$1,000. This AD&D benefit is payable to the covered person's <u>beneficiary</u>. The <u>seat belt</u> benefit is payable if you or your covered dependent are injured or die as a result of an automobile accident, and that person was: <ul style="list-style-type: none"> In an accident while driving or riding as a passenger in a <u>motor vehicle</u>; Wearing a <u>seat belt</u> which was properly fastened at the time of the accident; and Injured or died as a result of the <u>injuries</u> sustained in the accident. A police officer investigating the accident must certify that the <u>seat belt</u> was properly fastened. A copy of such certification must be submitted with the claim for benefits. The <u>air bag</u> benefit is payable only if the <u>seat belt</u> benefit is payable and if the person was positioned in a seat with an <u>air bag</u>, properly strapped in the <u>seat belt</u> when the <u>air bag</u> inflated. <p>Only the minimum <u>seat belt</u> AD&D benefit will be paid if it cannot be determined that the covered person was wearing a <u>seat belt</u> at the time of the accident.</p>
<p>Spouse Education</p> <p><i>Available if you die as a result of a <u>covered accident</u></i></p>	<ul style="list-style-type: none"> The spouse education AD&D benefit is equal to the tuition charges incurred for a period of up to four consecutive academic years as a full-time student in an accredited school. The maximum benefit is \$25,000 per academic year with an overall maximum of \$100,000; the minimum benefit is \$2,500. This benefit is payable to your surviving spouse, provided he or she enrolled within one year of your death. If there is no surviving spouse who qualifies for this AD&D benefit, an AD&D benefit of \$2,500 will be paid to your designated <u>beneficiary</u>.
<p>Day Care Benefit</p> <p><i>Available if you or your covered spouse die as a result of a <u>covered accident</u></i></p>	<ul style="list-style-type: none"> For each child, the annual day care AD&D benefit is the lesser of actual charges or 10% of the covered person's <u>principal sum</u>, up to a maximum AD&D benefit of \$10,000 per year. The minimum benefit is \$1,000. For each child, the AD&D benefit may be paid annually for four consecutive years, provided your covered child remains in day care. Proof that day care charges have been paid is required before payment of AD&D benefit. AD&D benefit will be made to the person who has primary responsibility for the child's day care expense. Day care charges incurred after the date a child attains age 12 will not be paid. This benefit pays for day care center charges incurred due to the accidental death of you or your covered spouse, provided: <ul style="list-style-type: none"> The child was enrolled in day care prior to or is enrolled in day care within 365 days after the covered person's death; and The day care center is operated and licensed according to the law of the jurisdiction where it is located; and provides care and supervision for children in a group setting on a regularly scheduled and daily basis. In the event you and your covered spouse die simultaneously, or you die while a day care benefit is being paid on account of your covered spouse's death, the total amount of AD&D benefit will not exceed the above maximum applied to the combined total of your and your spouse's <u>principal sums</u>. If there is no child who qualifies for this AD&D benefit, an AD&D benefit of \$1,000 will be paid to your designated <u>beneficiary</u>.

How Benefits Are Paid

If you die, AD&D benefits will be paid to your designated beneficiary(ies). All other AD&D benefit payments will be paid to person(s) designated by Plan provisions. Most AD&D benefits are paid in a single lump-sum payment. AD&D benefits are paid as soon as the insurer receives proof supporting the claim.

 “Naming or Changing Your Beneficiary,” at right

Exclusions and Limitations

✓ **Note:** This list of exclusions and limitations is not exhaustive. The terms of the insurance contract will control concerning events that do not qualify as a covered accident and, therefore, do not qualify for AD&D benefits.

AD&D benefits are not payable for injuries or death caused by, contributed to or resulting from any of the following conditions:


- Suicide or attempted suicide, whether sane or insane;
- Intentionally self-inflicted injury;
- War or act of war, whether declared or not, in the United States;
- Service as a full-time member of the armed forces (land, water, air) of any country or international authority except Reserve National Guard Service;
- Travel on any aircraft:
 - As a student pilot, crew member or pilot, unless it is owned or leased on behalf of the Company;
 - As a flight instructor or examiner; or
 - Being used for tests, experimental purposes, stunt flying, racing or endurance tests;
- Intake of drugs, including, but not limited to, sedatives, narcotics, barbiturates, amphetamines or hallucinogens, unless as prescribed by or administered by a physician;
- Committing or attempting to commit a felony; or

- Injured while intoxicated and is the operator of a vehicle or other device involved in the accident:
 - Blood alcohol content or results of other means of testing blood alcohol level or results of other means of testing other substances that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the incident occurred.

Naming or Changing Your Beneficiary


You must name a beneficiary (the person or persons designated to receive AD&D benefits in the event of your death). You may name as many beneficiaries as you wish — including individual persons, your estate, a trust, church or charitable organization.

- For spouse and dependent AD&D benefits, you’re the designated beneficiary, and no one else can be named (including a contingent beneficiary). If you and your dependent(s) die within the same 24-hour period, the AD&D benefits will be paid as described under “If You Don’t Have a Beneficiary.”

 “If You Don’t Have a Beneficiary,” page J-12

- If you designate more than one beneficiary without identifying their respective shares, the beneficiaries will share equally.
- When designating your beneficiary, provide the Social Security number and as much information as possible (e.g., full name, date of birth, current address).
- By law, benefits cannot be paid directly to a minor (anyone under 18 years old) or a legally incompetent person — benefits will be paid to the court-appointed guardian. In the absence of a court-appointed guardian, the Claims Administrator will hold the proceeds until the minor reaches age 18.
- If your marriage status changes (divorce, re-marriage, etc.), you may wish to make a new valid beneficiary designation. Advising the Company of your status change does **not** change your beneficiary designation. You must make a new beneficiary designation if you want to make changes to your existing designation. **If you named your spouse as your beneficiary prior to your divorce, your divorce does not automatically revoke your election and your ex-spouse will remain your beneficiary until you change your beneficiary designation.**

- Unless you specify otherwise, AD&D benefits for any beneficiary who dies before you, at the same time as you, or within 24 hours of your death will be paid as described under “If You Don’t Have a Beneficiary.”

 “If You Don’t Have a Beneficiary,” below

- From time to time, you may be required to make a new valid beneficiary designation for the purpose of administration of the Plan.

You can name or change your beneficiary designation at any time. Your beneficiary designation must be submitted online at <http://hr.conocophillips.com/contacts-resources/mybenefits> or by calling the Benefits Center. A beneficiary designation by any other means will not be accepted. Your valid beneficiary designation is effective on the date you (or the owner of your coverage, if you had assigned your coverage prior to Jan. 1, 2006) make the designation.

If You Don’t Have a Beneficiary

AD&D benefits will be paid according to the provisions shown below if:

- You didn’t designate a beneficiary;
- Your designated primary and contingent beneficiaries die before you, at the same time as you, or within 24 hours of your death; or
- For dependent AD&D benefits, your dependent dies at the same time as you or within 24 hours of your death.

The provisions state that the Claims Administrator may pay all or part of the AD&D benefits due in the following order:

- Your spouse, if alive;
- Your child(ren), if there is no surviving spouse;
- Your parent(s), if there is no surviving child;
- Your sibling(s), if there is no surviving parent; or
- Your estate, if there is no surviving sibling.


Any payments made will relieve the Claims Administrator of any liability for the Plan benefits.

How to File a Claim

To initially file a claim for AD&D benefits, you, a family member or a beneficiary should contact the Benefits Center and provide the covered person’s and employee’s name and Social Security number, date of the accident or death and contact information for next of kin. Claims must be received by the Benefits Center within 20 days of a loss due to a covered accidental injury or death. Delayed claims will be accepted if the accident was reported as soon as reasonably possible. Proof of loss should be submitted within 90 days of when it is due.

For death claims, a certified death certificate must be provided before any AD&D benefits can be paid. Other documents (for example, a copy of trust or estate documents) may also be required, depending on your beneficiary designations. The claimant will be advised if additional documents are needed to support a claim.

When you file a claim with the Plan, you’re consenting to the release of information to the Claims Administrator and granting certain rights to the Claims Administrator.

 “Information and Consents Required From You,” page N-31

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- ✓ The Benefits Center is the initial point of contact for all notice of claim submissions under the AD&D Plan. Send your completed claims and supporting documentation to the address shown in the claim packet.

 “Contacts,” page A-1


Claim Review and Appeal Procedure

For information about when to expect a response to your claim from the [Claims Administrator](#) and/or [Appeals Administrator](#) or how to file an appeal if your claim is denied, refer to the “Claims and Appeals Procedures” section.

 “[Claims and Appeals Procedures](#),” page N-26

When Coverage Ends

Your coverage will end on the earliest of the following events:

- The last day of the month in which your employment ends for any reason;
- The last day of the month in which you no longer meet the Plan’s eligibility requirements;
 “[Employee Eligibility](#),” page J-3
- The last day of the month in which your coverage is terminated for any other reason not stated in this section;
- The last day of the month in which you don’t pay the required costs;
- The last day of the month in which your [leave of absence](#)-Labor Dispute begins;
- The date of your death;
- The date on which the Company terminates AD&D coverage; or
- The date on which the ConocoPhillips Group Life Plan is terminated.


Coverage for your covered dependent(s) ends on the earliest of the following events:

- The last day of the month in which your coverage ends for any reason;
- The last day of the month in which your dependent no longer qualifies as an [eligible dependent](#) as defined by the Plan;
- The last day of the month in which coverage for your dependent(s) is terminated for any other reason not stated in this section;
- The last day of the month in which you don’t pay the required costs for dependent AD&D coverage;
- The last day of the month in which your dependent becomes eligible for coverage as a Company employee; or
- The date of your dependent’s death.

✓ Questions about benefit claims should be directed first to the representative handling your claim, who may direct you to the [Claims Administrator](#). The [Claims Administrator](#) approves or denies claims based on the applicable terms of the Plan documents, including the insurance contract.

 “[Contacts](#),” page A-1

✓ If your AD&D coverage ends, you may be eligible to continue your coverage.

 “[Continuation of Coverage](#),” page J-14

Continuation of Coverage

Contact the Claims Administrator to determine if you and/or your covered dependents are eligible for conversion provisions of your AD&D coverage as offered by the insurer.

Some rules apply to AD&D continuation of coverage:

- You may be eligible to continue AD&D coverage under conversion provisions.
- You must apply for continuation of coverage within the allowed days specified on the application that you will receive.
- The maximum coverage for you or your dependents is per Plan limits, unless your state has a lower maximum amount.
- You'll be billed monthly by the insurer.

✓ For information about AD&D continuation options, contact the Claims Administrator's office that administers conversion.

 "Contacts," page A-1

Short-Term Disability Plan

K

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✓ Please refer to the Glossary beginning on page O-1 for the definitions of underlined terms used throughout this SPD.

 "Glossary," page O-1

In this chapter, the term "Company" refers to ConocoPhillips and the other companies that have adopted this Plan.

Introduction

The ConocoPhillips Short-Term Disability (STD) Plan (the Plan) provides you with income if you're disabled and unable to perform the duties of your job due to a nonoccupational illness or injury.



Who Is Eligible

If you're an **active, regular full-time or regular part-time¹ employee**, you're eligible to participate in the Plan if you're a U.S. citizen or resident alien employee working within or outside the U.S. (includes rotators and U.S. expats) who is paid on the direct U.S. dollar payroll². Also eligible is a non-citizen, non-resident alien employee working in the U.S.

You're **not** eligible to participate in the Plan if your classification isn't described in this section. For example, temporary employees, intermittent employees, independent contractors, contingent workers, contract workers, leased employees and commission agents aren't eligible for the Plan.

Also, you're **not** eligible if you are on any other type of leave when you have a disability event, whether it be a personal, disability, labor dispute or military leave of absence or on a family medical leave of absence (FMLA) (if the FMLA began prior to the disability). Absences that might otherwise be considered STD absences but that occur during or extend into the period when the employee is absent due to a paid or unpaid absence or a leave of absence (e.g., Labor Dispute) are not covered by this Plan.

¹ Regular part-time employees must be regularly scheduled to work on average at least 20 hours per week.

² Direct U.S. dollar payroll means that payroll check is written in U.S. dollars by a U.S. company participating in the Plan and is not converted to another currency before being paid to the employee.

✓ Contact HR Connections for questions about whether your collective bargaining agreement expressly provides for your participation in the Plan or for variations in the Plan provisions.

 "Contacts," page A-1

How to Enroll

There are no enrollment requirements for short-term disability coverage.

When Coverage Begins

Coverage begins automatically on the first date you meet the Plan's eligibility requirements.

 "Who Is Eligible," at left

What the Plan Costs

The Company pays the entire cost of coverage under this Plan.

How the Plan Works

✓ Some of the Plan provisions described in this chapter may differ for employees who are covered by a collective bargaining agreement. In addition to the information in this chapter, employees covered by a collective bargaining agreement should refer to their separate collective bargaining materials for applicable provisions.

✓ Short-term disability benefits and a family medical leave of absence (FMLA) must run concurrently if all eligibility provisions for both are met. This includes an intermittent absence. You are responsible for contacting HR Connections to initiate the concurrent process of family medical leave of absence and STD for either full-time or intermittent absences.

Notice Requirements

You must notify your immediate supervisor of an absence due to a disability as far in advance as possible. If you can't give prior notice due to the nature of your disability, you must notify your immediate supervisor as soon as possible, **but no later than 24 hours** after your first absence from duty. If you incur a disability while on duty, you must report it to your immediate supervisor (or to another manager or supervisor if your immediate supervisor is unavailable) **before** leaving the work site. Be aware that inadequate notice may delay your receipt of STD benefits under the Plan. If you fail to provide the required notification, you will NOT receive STD Benefits.

STD Benefits


STD benefits are available for up to **1,000 hours at 100% of pay per calendar year** for nonoccupational illnesses or injuries. Benefits begin on the first regularly scheduled work day **after** you have completed the STD waiting period **and** a properly completed Employee Health Report (EHR) has been approved by the Plan. The 1,000-hour benefit and 40-hour STD waiting period may vary due to work schedules that are not 40 hours per week and/or 8 hours per day.

Under the Plan, hourly STD benefits are based on your regularly scheduled workweek or as defined by your local business unit policy or contract.

STD benefits are subject to the benefit reductions described in the “Benefits Reduction” section. Benefit requirements will vary based on the duration and type of disability absences.

Under the Plan, “pay” is defined as follows:

- **If you're a salaried employee**, pay is the average daily wage you would be paid for an individual day based on the number of work days in the particular pay period of the absence.
- **If you're an hourly employee**, pay is your hourly wage rate multiplied by your regularly scheduled hours in the pay period of the absence.
- Your annual pay is used for the kinds of compensation included and excluded from your “pay” for this Plan.

 “How Benefits Are Paid,” page K-8; “Benefit Reductions,” page K-7

- ✓ Absence benefits for a half-day, full-day or week-long absence will be based on the average number of hours the Company considers that you ordinarily work.

STD Waiting Period

The STD waiting period is 40 working hours of Paid Time Off Policy (PTO) you use prior to STD benefits beginning. The 40-hour requirement may vary due to work schedules that are not 40 hours per week and/or 8 hours per day. You may or may not be eligible for a different absence policy that provides a time off with pay benefit during these 40 work hours.

Additional STD waiting period requirements include the following:

- An STD waiting period must be met for each new, unrelated absence due to a disability.
- The STD waiting period must be for the same disability as the disability that qualifies for the STD benefit.
- An STD waiting period is expected to be met with PTO hours. You must obtain supervisor and Business Unit (BU) approval to use unpaid time to meet the STD waiting period.
- An STD waiting period is not required if a disability is approved for an STD benefit that is related to and taken immediately after a Postpartum Leave.

- An STD waiting period for intermittent absences related to the same chronic disability condition will only need to be met once per calendar year with an appropriate Employee Health Report or Company-provided form that has been submitted and approved by ConocoPhillips Health Services (COPHS). Please contact HR Connections for more information on how to initiate this process.
- A new STD waiting period is not required if you incur an unrelated disability while still off work receiving STD benefits for a separate disability.
- A new STD waiting period is not required if you return to work and have a related disability for which you previously met the STD waiting period in the same calendar year.

Examples of Related and Unrelated Absences:

- Unrelated Example:
An employee who has the flu in March and COVID in September will be treated as having unrelated absences. To the extent these illnesses result in absences longer than 40 hours, the STD waiting period will need to be met separately for each absence.
- Related Example:
An employee went out on surgery and used STD benefits after meeting the STD waiting period. Several weeks after surgery, the employee returned to work. The employee later developed complications from the surgery that required additional time off. Because the complications are related to the earlier surgery, a new STD waiting period is not required for STD benefits. For more information about these benefits, contact HR Connections.

To qualify for STD benefits under the Plan **AFTER** an STD waiting period has been met:

- You must be disabled;
- You must be covered under the Plan on the date you become disabled;
- You must have an EHR or Company-provided form approved by COPHS for STD benefits;
- If you're on scheduled time off under a Company-paid absence benefit policy on the date you become disabled, you must complete the scheduled paid absence before qualifying for STD benefits. (This provision does **not** apply if you're admitted to a hospital on an inpatient basis as a result of the disability.)

See "How to File a Claim" for information on applying for STD benefits.



"How to File a Claim," page K-10

- ✓ You may have legally required state or local paid sick leave laws that cover absences generally not covered by the Plan or which define hours for absences differently from this Plan. Please contact your local HR representative to discuss process requirements associated with these leave laws.

POSTPARTUM LEAVE

The Company provides 320 hours of Postpartum Leave eligible for STD benefits at 100% of pay for all birth mothers, regardless of the type of delivery and regardless of live or still birth (as defined by the American College of Obstetricians and Gynecologists), for the time you are unable to work due to labor and delivery. STD benefits under this provision will consider any STD benefits already received prior to the birth and deduct those amounts against your remaining STD benefits balance for the calendar year. The 320 hours of Postpartum Leave may vary due to work schedules that are not 40 hours per week and/or 8 hours per day. **Note:** The 320 hours of STD benefits for Postpartum Leave are available even if your remaining STD benefits are less than the 320 hours.

If You Are Disabled on First Work Day of Next Calendar Year

If you are receiving STD benefits on your first work day of the next calendar year, you will not qualify for the new calendar year 1,000 hours of STD benefits until you both return to work on your full-time work schedule for your employment status and you are capable of performing the usual and customary duties of your role (or modified duties in connection with an approved accommodation) for a period of at least 80 consecutive work hours without an absence. The period of 80 consecutive work hours is based on a 40-hour work week and may vary for work schedules that are not 40 hours per week and/or 8 hours per day. The following situations are not considered an absence and will not cause the 80-hour period to restart:

- Approved days under the Death in Family Leave Policy;
- Non work days on 19/30 and 9/80 work schedules;
- Holidays (unless you were scheduled to work on the holiday); and
- Approved time off for required civic duty such as jury duty.

Time off for any other reason will cause the 80-hour period to start over.

When new calendar year STD benefits are awarded after a disability that continued into the new calendar year, the new calendar year benefits will be reduced by any benefits already paid in the new calendar year.

EXAMPLE:

You're eligible for STD benefits up to a maximum of:

- 100% of pay for up to 1,000 hours

You became disabled and your first absence day was Dec. 4, 2025. You remained disabled through March 25, 2026.

During your 640 hours of disability, you received STD benefits as follows:

	<i>Paid in 2025</i>	<i>Paid in 2026</i>
• Benefits at 100% of pay	160 hours (Dec. 4 – Dec. 31)	480 hours (Jan. 1 – Mar. 25)

If you became disabled again **during 2026**, you could be eligible for a maximum of up to:

- 520 hours STD benefits at 100% of pay (1,000 – 480 = 520) after you meet another STD waiting period for an unrelated disability absence.

Note: This example does not account for any state-mandated sick pay or disability income benefits that the Benefits Committee determines you may be eligible for and that would be used to reduce your STD benefits.

-
- ✓ Due to the new Paid Time Off Policy effective Jan. 1, 2025, employees who are both receiving STD benefits on their last work day of 2024 and continue to be disabled on the first work day of 2025, will not receive 1,000 STD benefit hours for 2025 until they have returned to work or their full-time work schedule for their employment status and are capable of performing the usual and customary duties of their role (or modified duties in connection with an approved accommodation) for a period of 80 consecutive work hours (the period of 80 consecutive work hours is based on a 40-hour workweek and may vary for work schedules that are not 40 hours per week and/or 8 hours per day). Such employees will continue using their remaining 2024 STD benefit hours under the provisions of the 2024 STD Plan until they are eligible to receive the 1,000 STD benefits hours for 2025.
-

Benefit Reductions

STD benefits will be reduced by the amount of benefits you receive from Social Security and by the amount of benefits you are expected to be eligible for (as determined by the Benefits Committee) from any state-mandated sick pay or disability income program as a result of your disability.

- The reduction for state-mandated sick pay or disability income benefits will apply even if you don't apply for such benefits or if the amount received from such program is less (or more) than the amount expected, as determined by the Benefits Committee.
- As a result of the reduction, the combined total of (a) the amount you receive from Social Security and amount you are expected to be eligible to receive from any expected state-mandated sick pay or disability income program plus (b) the amount you receive under the STD Plan as a result of your disability, will not exceed 100% of your pay.

FOR EXAMPLE:

- You became disabled on Jan. 1, 2025, and remained disabled until June 30, 2025.
- Your pre-disability pay was \$15 per hour.
- You're eligible for STD benefits of up to:
 - 100% of pay for up to 1,000 hours¹ (\$15 per hour).
- The Benefits Committee determines that you are eligible for \$2.50 per hour in state-mandated disability income benefits for the first 640 hours of your disability.

Your STD benefits for your 1,000 hours of disability would be reduced to:

- \$12.50 per hour for up to 640 hours (*\$15.00 per hour STD Plan benefit less \$2.50 per hour state-mandated disability income benefit*); then
- \$15.00 per hour for the remaining period of up to 360 hours (*your STD Plan benefit would no longer be reduced for any state-mandated disability income benefit because you would no longer be eligible for such benefit*).

¹ Subject to reduction for any state-mandated sick pay or for disability income benefits which the Benefits Committee determines you may be eligible.

If You're Enrolled in the ConocoPhillips LTD Plan

The STD Plan provides for a maximum of 1,000 hours of STD benefits. If your disability lasts longer than 180 consecutive calendar days, benefits may be payable under the ConocoPhillips Long-Term Disability (LTD) Plan — provided you have enrolled in that plan and your LTD benefit claim is approved.

If you believe your disability will continue longer than 180 consecutive calendar days, it's your responsibility to file a notice of claim for LTD Plan benefits by contacting the Benefits Center as soon as possible.

 "Contacts," page A-1; "Long-Term Disability," page L-1

✓ STD benefit payments are deemed a substitute for the Company's legally required maintenance obligations under the Maritime Maintenance & Cure, including the Jones Act.

How Benefits Are Paid

After the required STD waiting period has been met, STD benefits will be paid as follows:

- **If you're a salaried employee:** Provided your supervisor is properly notified (as provided in this Plan) and COPS has approved your EHR, STD benefits start at the beginning of the first half day or full day of absence from work after the STD waiting period has been met. STD benefit hours will be deducted from your maximum STD benefit.
- **If you're an hourly employee:** Provided your supervisor is properly notified (as provided in this Plan) and COPS has approved your EHR, STD benefits start with your first full hour of absence from work, after the STD waiting period has been met. Each regularly scheduled hour that you're absent from work will be deducted from your maximum STD benefit.
- An employee will not receive STD benefits and also receive pay under another paid leave policy for the same day. For example, if you are unavailable to work on a holiday for reasons that qualify you for STD benefits, STD benefits would be paid, and holiday pay would **not** be paid.


Your STD benefits will never be more than what you would have earned for the same period as an active, non-disabled employee. Under some conditions, it could be less than the income you would have received if you had not experienced the STD absence. For example, your STD benefits would not include some kinds of annual pay you might otherwise have received.

Because you don't pay for your STD Plan coverage, STD benefits are subject to federal, state and/or local tax provisions.

✓ **Note:** Split classification employees (i.e., those regularly working a portion of their time on one job and a portion of their time on another job paid at a different rate) will receive benefits based on an equitable division of their time between the two rates, as determined by the Company.

Maximum Benefit Duration

The Plan provides for a maximum of 1,000 hours of STD benefits, and benefits will not be paid after 1,000 hours even if you're still disabled. If your disability lasts longer than 180 consecutive calendar days, benefits may be payable under the Long-Term Disability (LTD) Plan — provided you have enrolled in that plan and your LTD benefit claim is approved.

 “If You're Enrolled in the ConocoPhillips LTD Plan,” page K-7; “Long-Term Disability,” page L-1

When Benefits Are Not Paid

STD benefits will **not** be payable:

- If you have not met your STD waiting period;
- If you're terminated or not on duty due to layoff, resignation, retirement, discharge or any paid or unpaid leave of absence — regardless of whether any of these events occurred prior to or during a period of STD absence;
- While you're receiving any other type of income from the Company due to you as an employee — including, but not limited to, PTO, Parental Leave or holiday pay, or benefits received during a paid leave or disability-related policy;
- For any time during which you are disabled but are performing any work for yourself or any other person other than on behalf of the Company — regardless of whether the work is for pay or profit. **Note:** This provision does **not** apply if you have received written permission to perform the work, in advance, from your business unit's HR manager;
- If you're receiving benefits under the STD Plan for occupational injury and illness;
- For any time during which you or your attending physician delays treatment or surgery or prolongs the convalescent period beyond a typical period for such disability or surgery, as defined by evidence-based practice guidelines informed by clinical research, regardless of whether an EHR or other requested medical documentation is submitted. In extenuating circumstances, an extension may be granted at the discretion of COPHS;
- If you submitted false information about your disability to the Plan or withheld pertinent information about your disability from the Plan. Additionally, if you accept benefits based on false information, such action will be regarded as a breach of faith on your part, and you'll be subject to disciplinary action under the local disciplinary policy;
- If you fail to comply with any of the provisions or requirements of the Plan; fail to notify your supervisor of your absence; or fail to supply medical certification, an EHR or any additional documentation requested by the Plan;
- For any time during which you're not treated by a duly qualified physician after being absent from work for longer than your STD waiting period;
- For any time you are absent from work for preventative and diagnostic medical services not related to a disability for which you already met the STD waiting period;
- For any disability that occurred:
 - As a result of an activity of professional participation in hazardous sports;
 - As the result of intentionally self-inflicted injury or illness, regardless of your state of mind;
 - As the result of any employment for which you're entitled to benefits under any Workers' Compensation law or act or similar legislation (whether you're employed by the Company, by any other employer or because of self-employment);
 - While you were engaged in an illegal occupation;
 - As the result of war or act of war during military service;
 - While you were attempting or committing a crime; or
- For any time you are not following your physician's treatment or rehabilitation plan.

Returning to Work

When you're ready to return to work from an STD absence:

- You should notify your immediate supervisor in writing or by phone as soon as possible prior to the date you intend to return.
- You are required to provide an EHR from your physician, certifying that you do not have any physical, substance use disorder or mental health conditions that keep you from safely performing all essential functions of your job.
- In addition, based on your job duties, you may be subject to the following:
 - COPHS may require you to undergo a fitness for duty examination at the Company's expense before being allowed to return to work.
 - You may not be able to return to your prior job duties until COPHS clears you, even if your physician certifies in an EHR that you are able to perform all essential functions of your job.
 - You should submit an EHR as soon as your physician orders physical restrictions or prescribes prescription drugs that can impair your job performance.
- If you're unable to perform satisfactorily upon your return to work, you may be required to provide a statement from your physician concerning your ability to safely perform your job duties and/or be required to see another health care provider at the Company's expense.

Nothing in this Plan amounts to a promise that your employment will continue during the time you are receiving STD benefits or at the time you are released to return to work. ConocoPhillips will make all employment decisions considering local, state and federal laws and the employment policies of the Company.

-
- ✓ If you're covered by a collective bargaining agreement, contact HR Connections to determine if the collective bargaining agreement governing your location differs from the information stated in this "Returning to Work" section. In the event of a conflict, the collective bargaining agreement shall apply.

 "Contacts," page A-1

When Benefit Payments End

STD Plan benefit payments end at the earliest of the following events:

- The date you're no longer disabled;
- The date you fail to provide satisfactory proof of continuing disability;
- The date you don't have a medical examination as may be required by the Plan;
- The date you reach the 1,000-hour maximum benefit duration;
- The date COPHS releases you to return to work full-time or in transitional duty and you fail to do so;
- The date your eligibility for the Short-Term Disability Plan ends;
- The date your benefits under the ConocoPhillips Long-Term Disability Plan begin; or
- The date of your death.

How to File a Claim

Claims for payment of STD benefits are submitted for review once the STD waiting period has been met through completion of your Employee Health Report (EHR). The Benefits Committee utilizes COPHS to review and recommend approving or denying EHRs. COPHS may also provide a recommendation on whether the employee meets (or continues to meet) the Plan's definition of disability, but the decision is ultimately with the Claims Administrator.

The following are additional requirements (unless local practice or your collective bargaining agreement, if applicable, has a more stringent requirement):

- If your absence is caused by a nonoccupational illness or injury that starts on a scheduled work day and lasts longer than the STD waiting period, you must provide COPHS an EHR or other medical certification form authorized by COPHS to demonstrate eligibility for STD benefits. **The EHR must be completed by a physician.**
 - Your first EHR is due once the STD waiting period has been completed.
 - After your first EHR and while you're unable to safely perform regular work duties, the next EHR is due within 30 calendar days from the date of the last EHR. **Note:** If the EHR specifies the next physician appointment date, COPHS may utilize discretion to allow more than 30 calendar days between EHR submissions.
 - Your final EHR must be submitted on or before the day of returning to work without restrictions.
- If the EHR is incomplete or inadequate and more information is requested, the updated EHR must be submitted within seven calendar days from COPHS's request unless you have contacted COPHS and received an extension due to extenuating circumstances.
- The Benefits Committee has the authority to waive or change any of the Plan's requirements regarding EHR's as appropriate, in the Benefits Committee's sole discretion, to implement recommendations of the U.S. Department of Health and Human Services' Centers for Disease Control and Prevention (CDC) or other similar governmental public health agency.
- The Benefits Committee, on recommendation of COPHS, can waive the timing requirements for EHRs in circumstances in which obtaining an EHR is not beneficial to the management of the medical condition, or you have provided sufficient communication to COPHS and have received approval from the Chief Medical Officer.
- Bona fide evidence of full justification for every absence in which you receive STD benefits under this Plan must be presented in the EHR when requested by COPHS, which may include that an EHR is required more frequently than the outlined claim process.
- Other written statements or health records from your physician may be required as requested by COPHS.

- In certain instances, you may be required, at the Company's expense, to obtain a second medical certification from a health care provider to determine your eligibility for STD benefits under this Plan. If the opinions of the Company's health care provider and your provider differ, you may be required to obtain medical certification from a third health care provider, again at the Company's expense. If you have been denied STD benefits, an Independent Medical Examination may be available.

You must follow the process requirements described in this section before you can request a review of your claim denial. **Failure to submit timely written statements/health records, medical certification or EHR, as required or requested by the Plan, will result in loss of STD benefits which may include retroactive adjustments and/or disciplinary action, up to and including termination.**


You can obtain a copy of the EHR form from HR Connections, COPHS, or on hr.conocophillips.com.

✓ **You are responsible for contacting HR Connections to initiate the concurrent process of family medical leave of absence and STD for full-time or intermittent absence.**

✓ For additional information about requirements for medical certification and/or release to return to work following absences of five or more days, contact your local designated COPHS (medical) representative.

Claim Review and Appeal Procedure

If your claim is denied or there is a reduction or termination of your STD benefits, you may request a review of the claim denial or reduction. Your request must be in writing and delivered to the Appeals Administrator. For additional information about claims and appeals, including when to expect a response to your claim and how to file an appeal if your claim is denied, refer to the Claims and Appeals Procedures section of the Employee Benefits Handbook.

 “Contacts,” page A-1; “Claims and Appeals Procedures,” page N-26

When you file a claim with the Plan, you’re consenting to the release of information to the Claims Administrator and granting certain rights to the Claims Administrator.

UNCLAIMED PLAN FUNDS

In the event a benefits check issued on behalf of this self-insured Plan is not cashed within one year of the date of issue, the check will be voided, and the funds will be returned to this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event an eligible employee subsequently requests payment with respect to the voided check, the self-insured Plan shall make such payment under the terms and provisions as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied to the payment of benefits (including administrative fees) under the Plan pursuant to ERISA.

When Coverage Ends

Your coverage will end on the earliest of the following events:

- The date you have exhausted all STD benefits you are eligible to receive;
- The date your employment ends for any reason;
- The date you no longer meet the Plan’s eligibility requirements;

 “Who Is Eligible,” page K-3

- The date you fraudulently obtain benefits to which you were not entitled or it’s determined that one of the exclusions listed under “When Benefits Are Not Paid” applies;


 “When Benefits Are Not Paid,” page K-9

- The date of your death; or
- The date on which the STD Plan is terminated.

Long-Term Disability Plan

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✓ Please refer to the Glossary beginning on page O-1 for the definitions of underlined terms used throughout this SPD.

 “Glossary,” page O-1

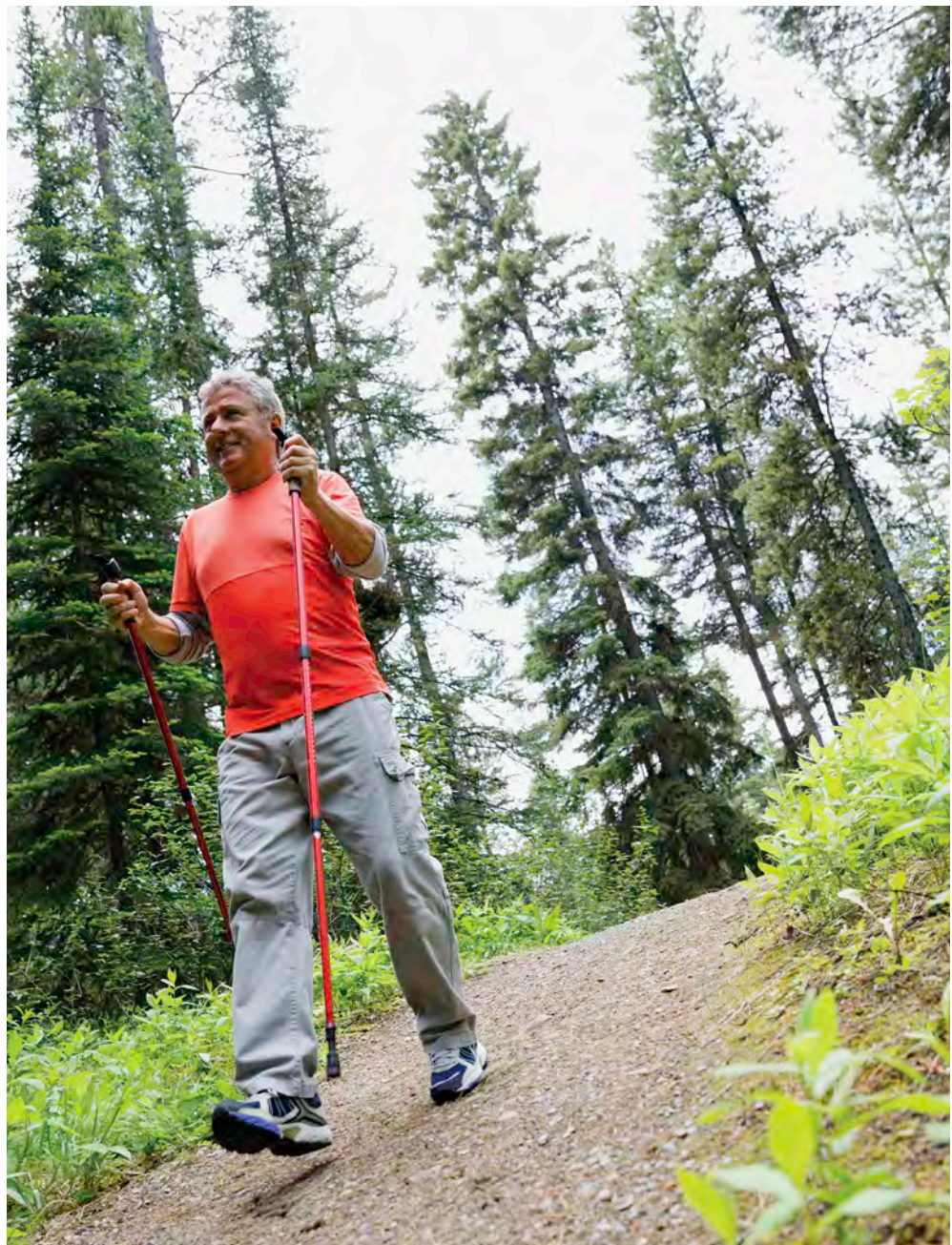
In this chapter, the term “Company” refers to ConocoPhillips and the other companies that have adopted this Plan.

✓ This Plan is not in lieu of, and does not affect, any requirement for coverage by Workers’ Compensation insurance or any government-mandated temporary disability income benefits law.

Introduction

The ConocoPhillips Long-Term Disability (LTD) Plan (the Plan) can help replace a portion of your regular paycheck if sickness, pregnancy, mental health, substance abuse or accidental bodily injury prevent you from working for an extended period of time (longer than 180 days). The Plan has been designed to provide valuable income protection at a competitive cost.

You can choose from two levels of coverage — basic or enhanced. Both coverage levels pay monthly LTD benefits for a certain period of time while you’re disabled and unable to work as determined by the LTD Claims Administrator.



Who Is Eligible

If you're an **active, regular full-time or regular part-time¹ employee**, you're eligible to participate in the Plan if you're:

- A U.S. citizen or resident alien employee working within or outside the U.S. (includes rotators and U.S. expats) who is paid on the direct U.S. dollar payroll²;
- A U.S. citizen or resident alien employee working within or outside the U.S. (includes rotators and U.S. expats) who is paid on the direct U.S. dollar payroll² and who is on a personal or disability leave of absence or on a family medical leave of absence; or
- A non-citizen, non-resident alien employee working in the U.S. or on a personal or disability leave of absence or on a family medical leave of absence.

You're **not** eligible to participate in the Plan if your classification isn't described in this section. For example, temporary employees, intermittent employees, independent contractors, contingent workers, contract workers, leased employees and commission agents aren't eligible for the Plan.

¹ Regular part-time employees must be regularly scheduled to work on average at least 20 hours per week.

² Direct U.S. dollar payroll means that payroll check is written in U.S. dollars by a U.S. company participating in the plan and is not converted to another currency before being paid to the employee.

✓ If you were disabled prior to Jan. 1, 2020


The provisions of the employer-sponsored LTD plan under which you had coverage when you were disabled (meaning the first day of your elimination period) are applicable for your LTD benefit claim. Please refer to your applicable LTD Summary Plan Description at the time of your disability.

✓ Contact the Benefits Center for questions about whether your collective bargaining agreement expressly provides for your participation in the Plan.

 "Contacts," page A-1

How to Enroll, Change or Cancel Coverage

If you want to enroll in, change or cancel long-term disability coverage, you enroll online or call the Benefits Center. Your enrollment materials will also contain information to help you make your enrollment elections. If you have questions about the enrollment procedure or need more information, contact the Benefits Center.

 “Contacts,” page A-1

When you enroll, you’ll:

- Choose from the Plan options available to you; and
- Authorize any required payroll deduction contributions for the coverage you select.

When to Enroll, Change or Cancel Coverage

You can enroll, change or cancel coverage at any time. Evidence of insurability will be required if you enroll more than 30 calendar days after the date you’re first eligible for coverage and for certain coverage elections.

 “When Evidence of Insurability Is Required,” at right

When Evidence of Insurability Is Required

Evidence of insurability (EOI) — also known as evidence of good health — is required proof of your good health that must be approved by the Claims Administrator before you will be covered by the Plan. You must supply EOI if:

- You elect coverage more than 30 calendar days after your eligibility date — that is, your hire date or the date you first become eligible;
- You change your LTD Plan coverage from “basic” to “enhanced”; or
- You re-enroll in the Plan upon your return from a leave of absence. If you are returning from a leave of absence-Labor Dispute, you’re automatically re-enrolled if the leave was 30 calendar days or less, and no EOI is required. If the leave of absence-Labor Dispute was more than 30 calendar days, you’ll be eligible for re-enrollment like a new hire, but EOI will not be required if you enroll within 30 calendar days and if the level of coverage is not increased. **Note:** You don’t need to provide EOI if you’re returning from a family medical leave of absence (FMLA), if you enroll in the same or a lower option as you had prior to going on your leave, and you enroll within 30 calendar days of your return to work. If you elect increased coverage after your return from any leave of absence, EOI will be required.


When Coverage Begins

The date your coverage begins depends on when you enroll.

If you enroll or change your coverage:	Coverage is effective:
Within 30 calendar days of your eligibility date (e.g., your hire date or the date you first become eligible to participate)	On your eligibility date
More than 30 calendar days after your eligibility date	On the first day of the month coincident with or following your enrollment and approval of any required <u>EOI</u> by the <u>Claims Administrator</u>
During annual enrollment ¹	On the following Jan. 1 or the first day of the month coincident with or following your enrollment and approval of any required <u>EOI</u> by the <u>Claims Administrator</u> , whichever is later
Any other time during the year ¹	On the first day of the month coincident with or following your enrollment and approval of any required <u>EOI</u> by the <u>Claims Administrator</u>
When you return to work as a regular full-time or regular part-time employee on or before the expiration of a <u>leave of absence</u> ² and did not continue coverage during the leave	On the first day of the month coincident with or following your enrollment and approval of any required <u>EOI</u> by the <u>Claims Administrator</u>
When you return to work as a regular full-time or regular part-time employee on or before the expiration of a military <u>leave of absence</u> ² if you did not continue coverage during your <u>leave of absence</u> , your coverage prior to the leave will automatically be reinstated without <u>EOI</u>	On the day you return to work
When you return to work from a <u>leave of absence</u> -Labor Dispute of 30 or less calendar days, your coverage prior to the leave will automatically be reinstated without <u>EOI</u> . <u>EOI</u> is required for any additional LTD insurance	On the day you return to work
When you return to work from a <u>leave of absence</u> -Labor Dispute of more than 30 calendar days, your coverage level prior to the leave will be available without <u>EOI</u> . <u>EOI</u> is required for any additional LTD insurance	<p>If you enroll WITHIN 30 calendar days of your eligibility date: On the day you return to work</p> <p>If you enroll MORE THAN 30 calendar days following your eligibility date: On the first day of the month coincident with or following your enrollment</p>

¹ You cannot increase coverage while you're on a leave of absence.

² See "If You Take a Leave of Absence" for further information on returning from a leave of absence.

 "If You Take a Leave of Absence," page L-6

For all of the dates shown in the chart above, coverage begins only if you're actively at work on that day. Otherwise, LTD Plan coverage will begin on the date you return to work for full pay on your normal schedule.

Changing Your Coverage

You can enroll in, change or cancel your LTD Plan elections at any time.


- Your new elections won't take effect until any required EOI has been accepted by the Claims Administrator.
- Unless otherwise noted, coverage changes will be effective on the first of the month coincident with or following your enrollment and approval of any required EOI.
- Cancellation of coverage will be effective on the last day of the month in which the cancellation is received.

If You Take a Leave of Absence

If you're on a leave of absence (excluding a disability leave of absence because you are receiving LTD benefits), you may continue your LTD Plan coverage for a maximum of 12 months during the approved leave period — provided you make any required contributions for coverage when they're due.

- During your leave, you pay the same cost for coverage that an active employee would pay.
 - If you're on a paid leave, your cost will continue to be deducted from your paycheck on an after-tax basis.
 - If you're not receiving a paycheck from the Company, you'll pay the costs to ConocoPhillips on an after-tax basis. (ConocoPhillips will bill you for the cost of coverage.)
- When you return to work, the Company will resume deducting the costs from your paycheck on an after-tax basis.

If you end your coverage while you're away on leave — or if your coverage is ended due to non-payment of required contributions — you must submit an enrollment form and provide EOI upon your return to work. **Note:** If you return from a family medical leave of absence (FMLA) and enroll within 30 calendar days, you will not be required to provide EOI.

 "Who Is Eligible," page L-3; "How to Enroll, Change or Cancel Coverage," page L-4

If You Have a Leave of Absence-Labor Dispute

If you're placed on a leave of absence-Labor Dispute, your long-term disability coverage will end on the last day of the month in which the leave begins. See the chart on page L-5 for coverage after you return to work. If you're on a leave of absence-Labor Dispute during a regularly scheduled annual enrollment, you'll not be eligible and a special annual enrollment period will be provided after you return from the leave of absence-Labor Dispute.

What the Plan Costs

You pay the cost of your LTD Plan coverage with after-tax dollars. Your cost depends on:

- Your pre-disability earnings; and
- Whether you elect basic or enhanced coverage.

When you enroll, you'll receive information about how to access the current costs. The Benefits Committee reserves the right to recover any underpayments by the participant, made through error or otherwise, by offsetting future payments, invoicing the affected participant, or by other means as the Benefits Committee deems appropriate.

During your elimination period, you must continue paying for your LTD coverage. This will ensure that you remain covered for any other disability that you may experience during the elimination period. You don't pay for your coverage while you're receiving LTD benefits for a disability.

 "Elimination Period," page L-7

How the Long-Term Disability Plan Works

To qualify for LTD benefits, you must:

- Be disabled, as defined below;
- Be unable to work for at least 180 days after the last day you were able to work at your own occupation with the Company (your elimination period); and



“Elimination Period,” at right

- File a claim for LTD benefits with and be approved by the Claims Administrator.



“How to File a Claim,” page L-14

-
- ✓ If you become disabled due to a pre-existing condition that you had in the three months prior to your Plan coverage beginning or your coverage changing from Basic to Enhanced coverage, LTD benefits are payable only if you have been a Plan participant for 12 full consecutive months prior to the first day of your resulting elimination period.
-

Qualifying Disabilities

“Disabled” or “disability” means that you’re prevented from performing one or more of the essential duties of your own occupation due to sickness, pregnancy, mental illness, substance abuse or accidental injury. See Glossary definition for additional provisions regarding your disability.



“Glossary,” page O-5


You will **not** qualify for LTD benefits if your disability results from:

- Commission of a felony;
- Active participation in a riot;
- Intentionally self-inflicted injury or attempted suicide; or
- Any act of war — whether declared or undeclared — insurrection or rebellion.

Elimination Period

The elimination period is the time period between the day you were last able to work at your own occupation with the Company and the day LTD benefits begin. You must be under the continuous care of a physician during your elimination period.

The elimination period ends the later of:

- 180 continuous calendar days of disability; or
 - The day your benefits under the Short-Term Disability (STD) Plan are exhausted; or
-  *“Short-Term Disability Plan,” page K-1*
- The day your Paid Time Off hours end or because all available Paid Time Off hours are exhausted. **Note:** You must use all available unused Paid Time Off hours greater than 80 hours before LTD benefits may begin.

During the elimination period, no LTD benefits are payable under the LTD Plan.

✓ Returning to work DURING the elimination period (trial work days)

- If you return to work for **30 days or less** (does not have to be consecutive days) before completion of your elimination period, you won't have to begin a new elimination period if you **become disabled again from the same cause**. Those work days will apply toward the completion of your elimination period.
- If you return to work for **more than 30 days** (does not have to be consecutive days) before completion of your elimination period, you will need to begin a new elimination period if you **become disabled again from the same cause**. Those work days will **not** apply toward the completion of your new elimination period.
- If you start an elimination period and return to work and then **become disabled from a different cause**, you must complete a new elimination period.

 "Qualifying Disabilities," page L-7

If You Become Disabled Again After the Elimination Period

If you have received at least one LTD benefit payment for a period of disability, recovered from the disability and returned to work, and then become disabled again, your elimination period is determined as follows:


- If you return to work for 180 days or less after completion of your elimination period, you won't have to begin a new elimination period if you become disabled again from the same cause.
- If you return to work but then stop working due to an **unrelated disability**, you must fulfill a new elimination period and be approved by the Claims Administrator as being disabled before LTD benefits will be payable for the new disability.
- If a new disability occurs while you're receiving LTD benefits, the new disability will be treated as part of the same period as your current disability. Monthly LTD benefits will continue while you remain disabled. The current disability for which you're receiving LTD benefits and the new disability are subject to both the maximum LTD benefit duration and limitations/exclusions that apply to the new cause of disability.

Contact the Claims Administrator if you have questions about how returning to work affects the elimination period.

 "Contacts," page A-1

How LTD Benefits Are Calculated

Your LTD benefits are calculated each month based on your pre-disability earnings, your level of coverage (basic or enhanced) and your income from other sources (as described under "LTD Benefit Reductions" and "Work Incentive LTD Benefit").

 "LTD Benefit Reductions," page L-10; "Work Incentive LTD Benefit," page L-12

Your Coverage Level

When you enroll in the LTD Plan, you elect either basic or enhanced coverage.

Basic Coverage

Basic coverage provides LTD benefits equal to 50% of your pre-disability earnings after you have completed the elimination period for as long as you're qualified to receive LTD benefits (subject to the maximum LTD benefit duration and potential LTD benefit reductions).

 "Elimination Period," page L-7; "Maximum LTD Benefit Duration," page L-13; "LTD Benefit Reductions," page L-10

BASIC COVERAGE CALCULATION EXAMPLE

At the time he became disabled, Paul's pre-disability earnings were \$6,400 a month. During his disability, he is receiving Social Security disability benefits of \$600 a month in addition to his LTD benefits. Here's how Paul's monthly LTD benefit is determined:

LTD benefit (50% of <u>pre-disability earnings</u>):	\$3,200 (50% x \$6,400)
Social Security disability benefit:	<u>600</u>
Total monthly income:	\$2,600

Paul will receive a \$2,600 monthly LTD benefit from the Plan and a \$600 monthly disability benefit from Social Security which together equals 50% of his pre-disability earnings.

Enhanced Coverage

Enhanced coverage provides LTD benefits equal to 60% of your pre-disability earnings after you have completed the elimination period for as long as you're qualified to receive LTD benefits (subject to the maximum LTD benefit duration and potential LTD benefit reductions).

 "LTD Benefit Reductions," page L-10

Maximum LTD Benefit

Your maximum LTD benefit may not exceed \$40,000 per month.

LTD Benefit Reductions

The LTD benefit you receive from the Plan, your income from certain sources (as described below) cannot be more than 50% or 60% of your pre-disability earnings based on your coverage level. Your LTD benefit will be reduced so that the total monthly income you receive from the Plan, together with the other sources, does not exceed 50% or 60% based on your coverage level.

- Benefits under any other employer-sponsored group disability insurance plan (no offset for individual disability insurance that you purchase direct from the insurer);
- Benefits under any other group health insurance policies that provide benefits for time away from work due to disability or under any group life policy that provides installment payments for permanent disability, if the Company contributes towards them or makes payroll deductions;
- Entitlements under any mandatory benefit law, any Workers' Compensation law, Maritime Maintenance & Cure law, occupational disease law or other similar law;
- Any third-party liability judgment or settlement you receive for loss of income as a result of claims against a third party;
- Disability entitlements from any federal, state, municipal or other governmental agency, including Canada;
- The basic reparations portion of loss of income law providing for payments without determining fault in connection with automobile accidents — excluding any supplemental disability benefits you purchase under a no-fault auto law;
- Benefits under any government-sponsored compulsory benefit program that provides payment for loss of time from your job because of your disability or from any other group disability income plan, fund or other arrangement, no matter what it's called, if the Company contributes toward it or makes payroll deductions for it;
- The estimated amount you'll receive under Social Security (including those received on behalf of your dependents) or Workers' Compensation if, at the time your LTD benefits begin, no final determination has been made about this LTD benefit. When the final determination is made, your LTD benefits will be recalculated, and any overpayment or underpayment will be corrected;
- Commencement of benefits from a defined benefit retirement plan (excludes non-qualified plans regardless of source of contributions) sponsored by a participating employer in this Plan or retirement benefits that you receive under the retirement plan of an employer who was a participating employer and who has, under agreement with ConocoPhillips, assumed responsibility for payment of retirement benefits that you would otherwise be entitled to under the retirement plan of a participating employer. Your monthly LTD benefit will be reduced by the amount of the straight-life annuity (adjusted for early commencement in accordance with the retirement plan provisions, if applicable) that would be payable on your retirement plan benefit commencement date regardless of the form of benefit payment elected. If your retirement benefit includes an offset by a qualified domestic relations order, the straight-life annuity before the qualified domestic relations order offset will be used to reduce your monthly LTD benefit. The same reduction provisions apply if your retirement benefit is paid as an involuntary lump-sum payment (due to minimum retirement plan rules); or
- Portions of payments you receive under the Plan's work incentive provisions.

 "Work Incentive LTD Benefit," page L-12

- ✓ If you became disabled (first day of elimination period) on Jan. 1, 2019 or after, your income from certain sources is limited to no more than 50% or 60% of your pre-disability earnings based on your coverage level.

If you became disabled (first day of elimination period) between Jan. 1, 2010 and Dec. 31, 2018, Social Security payments you receive on behalf of your dependents will be included as an LTD benefit reduction when determining the 70% limit of your pre-disability earnings.

If you became disabled (first day of elimination period) between Jan. 1, 2003 and Dec. 31, 2009, and were enrolled in either the basic or enhanced option, Social Security payments you received on behalf of your dependents were not included as an LTD benefit reduction when determining the 70% limit of your pre-disability earnings.

If you became disabled (first day of elimination period) between Jan. 1, 2003 and Dec. 31, 2009, and were enrolled in the enhanced option, you were eligible for a 50% benefit with an adjustment for inflation after 24 monthly LTD benefit payments.

In addition, if you became disabled (first day of elimination period) prior to April 15, 1991 under an LTD plan that was sponsored by Phillips Petroleum Company or its subsidiaries that adopted the Plan, Company-paid retirement benefits are not used in the LTD offset calculation.

If your disability income from other sources is not paid monthly — for example, if they are paid quarterly or annually — they will be prorated to a monthly amount for purposes of calculating your LTD benefit.

LTD BENEFIT REDUCTION EXAMPLE — BASIC COVERAGE

At the time she became disabled, Lucy's pre-disability earnings were \$6,000 a month. She had received a \$45,000 Workers' Compensation lump-sum benefit, which was deemed as being paid over 30 months (at \$1,500 per month) in addition to her LTD benefits. Here's how Lucy's monthly LTD benefit is determined:

LTD benefit (50% of <u>pre-disability earnings</u>):	\$3,000 (50% x \$6,000)
Workers' Compensation Award:	<u>- 1,500</u> (\$45,000 ÷ 30 months)
Total monthly income:	\$1,500

For the 30-month duration, Lucy will receive a \$1,500 monthly LTD benefit from the Plan and the award from Workers' Compensation.

Lump-Sum Payments

If you are paid other income benefits in a lump sum (except retirement plan benefits), you must provide proof of 1) the amount attributed to loss of income; and 2) the period of time covered by the lump sum or settlement. The lump sum or settlement will be pro-rated over this period of time. If the required information is not provided, it will be assumed to be for loss of income and a time period of 24 months. If a retroactive allocation is made, it could result in an overpayment of the LTD benefit. If there is an increase in the other income benefits after the date your LTD benefits started and the increase applies to all persons entitled to that other income benefit, the increase will not be included in your other income benefit amount.

Minimum LTD Benefit

Your LTD benefit won't be less than 15% of your pre-disability earnings. However, this minimum won't apply if you've been overpaid on your LTD Plan benefits.


Work Incentive LTD Benefit

With the approval from the Claims Administrator and/or your physician you may participate in a rehabilitation program while you're disabled and receiving LTD benefits. The Claims Administrator should be contacted in advance regarding any rehabilitation needs or return to work plans. When you work while disabled, you'll receive the sum of the following amounts for a period of up to 24 consecutive months¹:

- Your monthly LTD benefit; and
- The amount you earn for working while disabled.

¹ The 24-consecutive-month period will begin on the latter of your first day of work or at the end of the elimination period.

If the amount you receive from the Plan, work incentive LTD benefits and the sources listed under "LTD Benefit Reductions" exceeds 100% of your pre-disability earnings or indexed pre-disability earnings, your monthly LTD benefit will be reduced by the amount that exceeds 100% of those earnings. If you cease or refuse to participate in an offered rehabilitation program, your LTD benefit will end.

 "LTD Benefit Reductions," page L-10; "Minimum LTD Benefit," at left

You must keep the Claims Administrator informed if you return to work in any capacity and at any job in order to receive the correct LTD benefit.

How LTD Benefits Are Paid

If the Claims Administrator determines that you qualify for LTD benefits under the Plan, your payments will begin on the first of the month after you complete your elimination period.

 "Elimination Period," page L-7

Provided you remain disabled, subsequent LTD benefits will be paid to you on the first of each month and will represent payment for the period of the previous month. After you begin receiving LTD benefit payments, your monthly LTD benefit won't be affected by termination of the Plan, termination of your coverage, or any Plan changes that become effective after the date you became disabled.

 "Qualifying Disabilities," page L-7

If you're disabled for only a part of a month, your LTD benefit payment for that month will be prorated to reflect the number of days you were disabled. Each month is counted as having 30 days, regardless of the actual number of days in a month.

PRORATING EXAMPLE

If your pre-disability earnings are \$2,400, and you're approved for LTD benefits beginning on April 11, your LTD benefit payment for April would be \$800. That amount is calculated by taking your monthly LTD benefit of \$1,200 (50% of your \$2,400 pre-disability earnings), divided by 30 days (\$40 per day), times the days of the month for which LTD benefits are paid (20). Twenty days at \$40 per day equals \$800.

Because you pay for LTD coverage with after-tax dollars, any LTD benefits you receive from the insurer will not be taxable to you. (However, U.S. tax laws do change. If you receive LTD benefits under this Plan, you should consult with a tax professional when filing your income tax returns.)

Maximum LTD Benefit Duration

Your LTD benefit may not exceed these maximum durations:

Age on Disability Start Date (first day of elimination period)	Maximum LTD Benefit Duration ^{1,2}
Under age 65	To the end of the month in which you reach age 65 ³
Age 65 and over	12 months

¹ If you became disabled (first day of elimination period) between April 15, 1991 and Dec. 31, 2000 under an LTD plan that was sponsored by Phillips Petroleum Company or its subsidiaries that adopted the Plan, you are eligible for a lifetime LTD benefit (subject to applicable benefit reduction provisions) and are not subject to the above durations.

² The duration will never be less than 12 months, provided your disability is continuous.



³ Plan benefits will be limited when disability results from mental illness, alcoholism, or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance (for claims that first day of elimination period is Jan. 1, 2020 or after). Benefits will be payable for a lifetime maximum of 24 months if you have been discharged from a medical confinement and are still disabled. The 24-month lifetime maximum will not apply while you are confined in a hospital or other place licensed to provide medical care for the disabling condition.

✓ Concurrent Disabilities

If a new, unrelated disability occurs while you're receiving LTD benefits, the new disability will be under the same maximum LTD benefit period as your current disability. Both disabilities will be subject to all limitations and exclusions that apply to the new disability.


When LTD Benefit Payments End

LTD benefit payments end at the earliest of the following events:

- The date you're no longer disabled, as determined by the Claims Administrator;
 *"Qualifying Disabilities," page L-7*
- The date you fail to provide the Claims Administrator with satisfactory proof of continuing disability;
- The date you fail to attend a medical examination as requested by the Claims Administrator;
- The date you refuse to receive recommended treatment that is generally acknowledged by physicians to cure, correct or limit the disability;
- The date you cease or refuse to participate in an offered rehabilitation program;
- The date your current monthly earnings are equal to or greater than 80% of your indexed pre-disability earnings if you are receiving LTD benefit for being disabled from your own occupation;
- The date your current monthly earnings are greater than the lesser of your indexed pre-disability earnings and your basic or enhanced coverage percentage or the maximum monthly LTD benefit if you are receiving LTD benefits for being disabled from any occupation;
- The date you reach the maximum LTD benefit duration; or
 *"Maximum LTD Benefit Duration," page L-13*
- The date of your death. If you die, unpaid LTD benefits for the month of your death will be paid in the following order:
 - To your spouse, if living;
 - To your children, if living, in equal shares; or
 - To your estate. If LTD benefits are payable to your estate, the Claims Administrator may pay up to \$1,500 to someone related to you by blood or by marriage whom the Claims Administrator deems entitled to this amount. The Claims Administrator's responsibility will be discharged to the extent of any payment made in good faith.

How to File a Claim

If you believe you may be disabled as defined by the Plan and expect your disability to continue beyond the end of the elimination period, you should file a notice of claim as soon as possible after your disability begins by contacting the Benefits Center. **This will help avoid interruption of your income if you are approved for LTD benefits.**

 *"Qualifying Disabilities," page L-7; "Elimination Period," page L-7*

✓ The Benefits Center is the initial point of contact for all notice of claim submissions under the LTD Plan. To file a notice of claim, you should contact the Benefits Center and provide the following information:

- Your name,
- Your Social Security number, and
- Your last day worked.

 *"Contacts," page A-1*


After your notice of claim has been filed, you'll receive a "proof of disability" packet from the Claims Administrator. You and your physician(s) must complete the forms at your own expense and return them to the Claims Administrator no later than three months after the end of your elimination period. The Claims Administrator may also require you to file supplemental proofs of claim at your expense and undergo physical examinations by a medical specialist of its choice at the Claims Administrator's expense. If you do not provide satisfactory supplemental documentation within 60 days after the date the Claims Administrator asks for it, your claim may be denied.

The following documentation will be required:

- Proof of disability — including, but not limited to, the date your disability started, the cause of your disability and the prognosis of your disability;
- Proof of continuing disability;
- Proof that you're under the appropriate care and treatment of a physician throughout your disability;

- Proof that you have applied for Social Security disability benefits until denied at the Administrative Law Judge level. The Claims Administrator provides assistance in this process; contact the Claims Administrator for information;

 “Contacts,” page A-1


- Proof that you have applied for Workers’ Compensation benefits or benefits under a similar law. If you don’t provide proof that you have applied for these benefits, the Claims Administrator may reduce your monthly LTD benefit. The reduction will be based on the Claims Administrator’s estimate of what you may be expected to receive;
 - Proof that you have applied, or are not eligible, for any of the amounts listed under “LTD Benefit Reductions.” If you don’t provide proof that you have applied for any of the items listed under “LTD Benefit Reductions,” the Claims Administrator may reduce your monthly LTD benefit;
-  “LTD Benefit Reductions,” page L-10
- Information about any amounts that are listed under “LTD Benefit Reductions”; and
 - Any other material information related to your disability that may be requested by the Claims Administrator.

LTD benefits are not payable for claims submitted more than one year after the date of your disability. However, you can request LTD benefits for late claims if you can show it was not reasonably possible for you to furnish proof of disability during the one-year period and you provided satisfactory proof as soon as reasonably possible.

-
- ✓ The Claims Administrator has been delegated total responsibility for determining LTD benefits under the Plan. Claims will be approved or denied by the Claims Administrator based on the terms of the LTD Plan, including the underlying insurance policy. Questions about LTD benefit claims should be directed to the Claims Administrator.

 “Contacts,” page A-1

When you file a claim with the Plan, you will be required to provide signed authorization to release medical and financial information to the Claims Administrator.

 “Information and Consents Required From You,” page N-31


Claim Review and Appeal Procedure

For information about when to expect a response to your claim from the Claims Administrator and/or Appeals Administrator or how to file an appeal if your claim is denied, refer to the “Claims and Appeals Procedures” section.

 “Claims and Appeals Procedures,” page N-26

When Coverage Ends

Your coverage will end on the earliest of the following events:

- The last day of the month in which your employment ends for any reason;
 - The last day of the month in which you no longer meet the Plan’s eligibility requirements;
-  “Who Is Eligible,” page L-3
- The last day of the month in which your coverage is terminated for any other reason not stated in this section;
 - The last day of the month in which you don’t make the required contributions;
 - The last day of the month in which your leave of absence-Labor Dispute begins. Note: If you return to work in less than 30 calendar days, your coverage will automatically be reinstated;
 - The last day of the month in which you go on strike, are locked out or are laid off;
 - The date of your death; or
 - The date on which the LTD Plan is terminated.

Severance Pay Plan



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✓ Please refer to the Glossary beginning on page O-1 for the definitions of underlined terms used throughout this SPD.

📄 “Glossary,” page O-1

In this chapter, the term “Company” refers to ConocoPhillips Company and the other companies that have adopted this Plan.

Introduction

The ConocoPhillips Severance Pay Plan may provide severance benefits (as well as supplemental benefits to participants who release the Company from employment-related claims) that give employees a measure of security when events result in involuntary loss of employment. These benefits may include severance pay and other special transition provisions. Other compensation or benefits payable at layoff are covered in other plans, programs, policies and communications.



Who Is Eligible

You are eligible to participate in the Plan if you are a regular full-time or regular part-time¹ employee in salary grade 22 or below, are on a participating employer's direct U.S. dollar payroll², and are not otherwise excluded from the Plan.

Regardless of the above, you're NOT eligible to participate in the Plan, if you are:

- A temporary, intermittent, contract or "leased" employee; or
- An employee covered by a collective bargaining agreement, unless the agreement expressly provides for participation in the Plan by naming the Plan. Generally, even if their collective bargaining agreement specifically provides for coverage under the Plan, such employees aren't eligible to participate in the Plan while they're on leave of absence-Labor Dispute.

¹ Regular part-time employees must be regularly scheduled to work on average at least 20 hours per week.

² Direct U.S. dollar payroll means that the payroll check is written in U.S. dollars by a U.S. company participating in the Plan and is not converted to another currency before being paid to the employee.

Qualifying Circumstances

You are eligible to receive benefits under the Plan if you have all the Qualifying Circumstances shown below and meet all other conditions required by the Plan. You have Qualifying Circumstances if:

- You are laid off on or after March 13, 2004;
- The Company gives you a written notice of layoff;
- Your employment with a participating employer involuntarily terminates following the notice of layoff on a date determined by the Company;
- Your termination meets one of the conditions below:
 - You are a salary grade level 20 or below and your termination of employment is either caused by a reduction in force, a job elimination, or a corporate event, or is designated as a layoff by the Chief Executive Officer of ConocoPhillips Company;
 - You are a salary grade level 21 or 22 and your termination of employment is designated as a layoff by the Chief Executive Officer of ConocoPhillips Company; or
 - Your termination of employment is on or after a Change of Control and is either caused by a reduction in force, a job elimination or a corporate event, or is designated as a layoff by the Chief Executive Officer of ConocoPhillips Company;
- You are an employee on the date of layoff; and
- You have completed or will complete one year of service as of the date of layoff. Completion of two or more years of service as of the date of layoff is required to be eligible for supplemental benefits.

Disqualifying Circumstances

Even if notice of layoff has been given, you're **not** eligible for severance benefits if:

- Your employment is voluntarily terminated and is not on a date determined by the Company;
- Your employment is terminated as a result of a corporate event (sale of assets, sale of stock, joint venture, outsourcing, etc.), and a successor employer offers you a job with comparable pay (at least 80% of your prior regular base pay, including regularly scheduled overtime, but not including overtime due to the 19/30 program);
- Your employment is terminated as a result of a corporate event, and you accept any job offered by a successor employer;
- You are on a leave of absence, excluding military leave of absence and leave of absence under FMLA; or
- You are terminated for cause as recorded by the Company.

You may be required to provide documentation about or self-certify facts regarding pay or any job offer by a successor employer.

Furthermore, if you were otherwise eligible for benefits under the Plan, you would **not** be eligible for severance benefits if:

- You failed to waive benefits under any other layoff plan, severance plan or similar program maintained by the Company (other than a retention bonus);
- You received layoff pay or termination pay under a negotiated working agreement or collective bargaining agreement;
- You're an hourly employee covered by a collective bargaining agreement or working policy and you have not exhausted your rights to displace less senior employees in the same work unit;
- At the time benefits would be paid, you owe money to the Company — including an obligation to repay benefits received from this Plan or any other severance plan of the Company — and no arrangement satisfactory to the Company has been made to repay such obligation; or
- You waived benefits under this Plan.

If the Company has given you a notice of layoff, it should also be noted that your termination will **not** be considered a layoff if any of the following apply:

- You resign as of a date prior to the date specified for layoff in the notice of layoff;
- Your employment is terminated because you failed to accept, within seven (7) calendar days of the offer:
 - A job offered by an employer at comparable pay, at a comparable employment level, but not in the same geographical area for which you will receive relocation assistance;
 - A job offered by an employer at comparable pay, at a comparable employment level and in the same geographical area; or
 - A transfer job at comparable pay offered by an affiliate that is not an employer made pursuant to a mutual agreement between the Company and the affiliate providing for such transfer job offer; or
- You accept any transfer job offered by an affiliate that is not an employer made pursuant to a mutual agreement between the Company and the affiliate providing for such transfer job offer.

How to Enroll

Participation in the Plan is automatic — you do not need to enroll.

What the Plan Costs


The Company pays the entire cost of the Plan — employee contributions are not required or allowed.

Severance Pay Plan Benefits

The Plan provides the following benefits:

- **Basic/minimum benefit:** Four weeks' pay; no General Release of Liability required; and
- **Supplemental benefits:** Three weeks' pay for each year of service, less the basic benefit.


The maximum total benefit (basic and supplemental benefits combined) is 60 weeks' pay.

 "Supplemental Benefits," at right

Severance Benefits

Basic Benefit

The basic benefit is four weeks' pay and is payable to you if you are eligible to receive benefits under the Plan, regardless of whether you sign a Release.


 "Qualifying Circumstances," page M-3

Supplemental Benefits

You become eligible for supplemental benefits when you:

- Have completed two or more years of service as of the date of layoff;
- Are eligible to receive benefits under the Plan; and
- Have signed and returned a General Release of Liability (within 60 calendar days after the date of layoff) which releases the Company from liability for employment-related claims. The Release must be in the form accepted by the Company and must be returned by the required deadline.

Supplemental benefits are three weeks' pay for each year of service, up to a maximum of 60 weeks' pay, less the basic benefit of four weeks' pay.

 "Qualifying Circumstances," page M-3; "General Release," page M-7

FORMER SHELL ENTERPRISES LLC EMPLOYEE SEVERANCE BENEFITS

These benefits apply to former Shell Enterprises LLC employees who transferred to ConocoPhillips with the Permian assets and who receive a notice of layoff dated Dec. 1, 2021 through Nov. 30, 2023. **The Plan's Basic and Supplemental Benefits are not available to these employees.** To receive these benefits a General Release of Liability (Release) is required per the provisions on page M-7

 "General Release," page M-7

- Three (3) weeks' pay for each year of service:
 - Minimum of 12 weeks.
 - Maximum of 78 weeks (26 years of service or more).
- COBRA premium Company portion as a cash payment:
 - Must be enrolled in a Company medical plan option on the termination date.
 - Participant must **not** meet the minimum eligibility requirements for the Company's retiree medical coverage.
- Educational Reimbursement:
 - Education reimbursement is available up to \$2,000 for tuition, required fees and books for course work that will help you transition to a new job with another company and is approved by designated Human Resources personnel.
 - A plan of course studies that can reasonably be expected to lead to re-employment must be submitted within 90 days after layoff.
 - Enrollment must be in course studies from an accredited college, university, trade school or that are part of a certified/license instructional program.
 - Courses and reimbursement requests should be completed no later than the first anniversary of the date of layoff and include evidence of satisfactory completion of courses and receipted bills for tuition and books.
 - Educational costs that are reimbursed by any federal, state or local governmental agency or by any private source **won't** be reimbursed by the Plan.

Total Layoff Pay

The following table shows the total layoff pay you may receive, depending on your length of service, assuming you are eligible for supplemental benefits:

Total Layoff Pay (Basic Benefit + Supplemental Benefits)	
Years of Service	Weeks' Pay
Less than 1	0
1	4 (<i>Basic Benefit</i>)
2 – 19	6 – 57 (<i>3 weeks for each year of service</i>)
20 or more	60

✓ Limit on Supplemental Benefits

In order to comply with the American Jobs Creation Act of 2004, supplemental benefits will be reduced, if necessary, so that the total of the basic benefit and the supplemental benefit does not exceed two times the maximum amount of compensation that may be taken into account under a qualified pension plan under Internal Revenue Code Section 401(a)(17) for the calendar year before the calendar year in which the layoff occurs.

General Release

To receive supplemental benefits, you must sign a General Release of Liability (Release) and provide the Release to the Benefits Committee or your Human Resources representative by the 60th calendar day after the date of layoff. If the 60th calendar day is a scheduled Company or a U.S. Post Office holiday, the Release must be received by the next business day. A faxed copy of the Release will be accepted, as long as it is followed by the original signed Release.

 “Plan Administration,” page N-4; “Contacts,” page A-1

The Release must remain unrevoked in order to receive full payment of benefits from the Plan. The Release is revocable during a seven-day period and after seven days, it’s irrevocable:

- If faxed, the seven-day revocation period starts when the fax of the signed release is received by the Company; or
- If by U.S. mail, the seven-day revocation period starts when the signed release is received in a Company office.

✓ If You Die

If you die after receiving a notice of layoff but before signing the General Release of Liability, your spouse or the representative of your estate must sign the Release and return it by the specified deadline for supplemental benefits to be paid.

Either you, your surviving spouse or representative of your estate (if you’re deceased), or the Company may request that the deadline to return the Release be extended if more time is needed to clarify issues relating to the scope or coverage of the Release. The Benefits Committee will approve such extensions when warranted. An extension will not be granted merely to extend the time that benefit payments would otherwise be made under the Plan.

 “Plan Administration,” page N-4

If the Benefits Committee doesn’t receive the executed Release by the required deadline (including any approved extensions), you (or your spouse or estate) won’t be entitled to supplemental benefits.

Only the basic benefit of four weeks will be paid.

EXAMPLES OF BENEFIT CALCULATIONS

The following examples show how benefits are calculated. These examples have been rounded to the nearest dollar; however, rounding will not be used in actual calculations.

Example 1 – 10 Years Service

Assumptions:

- Pat has worked continuously for the Company since Aug. 1, 2006.
- His regular monthly base salary rate is \$2,600, so his weekly pay is \$600 ($\$2,600 \div 4.3333$).
- Pat has satisfied all eligibility requirements for the Plan.

Pat receives a notice of layoff and is laid off on June 15, 2016. He has 10 years of service (2006 – 2016) and is eligible for 30 weeks' pay (10 years of service times 3 weeks' pay). His benefit is calculated as follows:

Pat signs and returns the Release within 60 days of his date of layoff:

$$\begin{array}{r} \$ \quad 600 \text{ (week's pay)} \\ \times \quad 30 \text{ (total weeks of layoff pay eligibility)} \\ \hline \$ 18,000 \text{ layoff pay} \end{array}$$

Pat does **not** sign and return the Release within 60 days of his date of layoff:

$$\begin{array}{r} \$ \quad 600 \text{ (week's pay)} \\ \times \quad 4 \text{ (total weeks from basic benefit)} \\ \hline \$ \quad 2,400 \text{ layoff pay} \end{array}$$

Example 2 – 25 Years Service

Assumptions:

- Robin has worked continuously for the Company since March 1, 1991.
- Her regular monthly base salary rate is \$4,335, so her weekly pay is \$1,000 ($\$4,335 \div 4.3333$).
- Robin has satisfied all eligibility requirements for the Plan.

Robin receives a notice of layoff and is laid off on May 16, 2016. She has 25 years of service (1991 – 2016) and is eligible for 60 weeks' pay (*the maximum benefit reached at 20 years of service*). Her benefit is calculated as follows:

Robin signs and returns the Release within 60 days of her date of layoff:

$$\begin{array}{r} \$ \quad 1,000 \text{ (week's pay)} \\ \times \quad 60 \text{ (total weeks of layoff pay eligibility)} \\ \hline \$ 60,000 \text{ layoff pay} \end{array}$$

Robin does **not** sign and return the Release within 60 days of her date of layoff:

$$\begin{array}{r} \$ \quad 1,000 \text{ (week's pay)} \\ \times \quad 4 \text{ (total weeks from basic benefit)} \\ \hline \$ \quad 4,000 \text{ layoff pay} \end{array}$$

Benefit Payments

Both basic benefits and supplemental benefits will be paid as lump-sum cash payments. All benefit payments from the Plan will be made as soon as practical after requirements for the payment have been met. Required federal and/or state taxes will be withheld from your payments. Hypothetical taxes will be withheld for expatriate employees.

Errors or Misstatements

An adjustment will be made in an equitable manner to conform to the facts if:

- The Company or its agents or representatives make an error determining eligibility for benefits, calculating benefits or administering the Plan; or
- You or your beneficiary make a misstatement (or fail to state a material fact) in an application or claim for benefits or in response to a request for more information from the Company.

Such adjustments could include a requirement that you or your beneficiary repay part or all of a payment previously made to you or your beneficiary.

Waiver of Benefits

You may waive benefits under the Plan by filing a written waiver with the Benefits Committee. The waiver must be in proper form, must apply to all benefits payable under the Plan, and must be irrevocable.

 “Plan Administration,” page N-4

In the Event of Your Death

If you die after both receiving notice of layoff and having been involuntarily terminated but before receiving the layoff pay that you otherwise would have been entitled to, payment will be made to your surviving spouse, or to your estate if you were not married at the time of death. To receive supplemental benefits, your surviving spouse or the representative of your estate must sign a General Release of Liability, and it must be received by the Company by the latter of 60 days after your death or the deadline cited on the Release, which is generally the 60th calendar day after a Release is provided to your surviving spouse or representative of your estate.

 “Supplemental Benefits,” page M-5; “General Release,” page M-7

What Happens If You're Rehired

If you are rehired after June 30, 2007 or become an employee of the Company after that date after having received severance or layoff pay associated with a period of employment that will be recognized in your company service date — your years of service for calculation of benefits under this Plan will be determined using your Severance Service Date (SSD) under the Service Recognition Policy of the Company, and no repayment of your layoff pay will be required under the Plan.

If you receive layoff pay under the Plan and are rehired by the Company, you'll become eligible for benefits again only if you:

- Satisfy the rules for eligibility to be a participant; or
- Satisfy the rules to receive benefits.

 "Total Layoff Pay," page M-6

EXAMPLE

Assumptions:

- You were laid off after 20 years of service and received 60 weeks of layoff pay.
- You're rehired 25 weeks after your initial layoff, and then you're laid off again.

You would not be required to repay any of the initial layoff pay, but your layoff pay associated with your second period of employment would be calculated using your SSD. As a result, none of the service for which you had received earlier layoff pay would be recognized.

How to File a Claim

You do not need to file a claim to qualify for Severance Pay Plan benefits; they are paid automatically. However, you may file a claim if you believe you are entitled to benefits under the Severance Pay Plan but do not receive them. The claim must be presented in writing to the Benefits Committee within 24 months after your termination date with the Company.

 "Severance Pay Plan Claims," page N-39

Claim Review and Appeal Procedure

For information about when to expect a response to your claim from the Benefits Committee and/or Appeals Administrator or how to file an appeal if your claim is denied, refer to the "Severance Pay Plan Claims" section.

 "Severance Pay Plan Claims," page N-39

When the Plan Changes or Ends

Although it is intended that the Plan continue indefinitely, ConocoPhillips Company may amend, modify, suspend, withdraw or terminate the Plan at any time.

Subsidiary companies that have adopted the Plan have the right to decline amendments with respect to their employees' participation and to end their participation in the Plan at any time.

No amendment, termination, suspension or withdrawal of the Plan will affect any benefits which may be payable to you if you have satisfied all of the eligibility requirements and become entitled to receive a benefit which has not been paid in full as of the effective date of amendment, termination, suspension or withdrawal.

The Plan cannot be amended, terminated, suspended or withdrawn within 24 months after a Change of Control, as defined in Appendix A, except:


- The Plan can be amended to comply with legal requirements; and
- The Plan can be amended to make changes that don't negatively affect participants' eligibility for benefits, amount of benefits or other rights under the Plan.

These restrictions apply to the 24 months after the occurrence of the first event that is deemed a Change of Control, and lapse after 24 months, regardless of whether another event that is deemed a Change of Control occurs.

 "Appendix A — Change of Control Provisions," at right

Appendix A — Change of Control Provisions

The following definitions apply to the Change of Control provision defined below for this Plan (see handbook Glossary for definitions of all other terms):

 "Glossary," page O-1"

affiliate: Shall have the meaning ascribed to such term in Rule 12b-2 of the General Rules and Regulations under the Exchange Act, as in effect at the time of determination.

associate: Shall mean, with reference to any person:

- (a) Any corporation, firm, partnership, association, unincorporated organization or other entity (other than ConocoPhillips or a subsidiary of ConocoPhillips) of which such person is an officer or general partner (or officer or general partner of a general partner) or is, directly or indirectly, the beneficial owner of 10% or more of any class of equity securities;
- (b) Any trust or other estate in which such person has a substantial beneficial interest or as to which such person serves as trustee or in a similar fiduciary capacity; and
- (c) Any relative or spouse of such person, or any relative of such spouse, who has the same home as such person.

beneficial owner: Shall mean, with reference to any securities, any person if:

- (a) Such person or any of such person's affiliates and associates, directly or indirectly, is the "beneficial owner" of (as determined pursuant to Rule 13d-3 of the General Rules and Regulations under the Exchange Act, as in effect at the time of determination) such securities or otherwise has the right to vote or dispose of such securities;
- (b) Such person or any of such person's affiliates and associates, directly or indirectly, has the right or obligation to acquire such securities (whether such right or obligation is exercisable or effective immediately or only after the passage of time or the occurrence of an event) pursuant to any agreement, arrangement or understanding (whether or not in writing) or upon the exercise of conversion rights, exchange rights, other rights, warrants or options, or otherwise; provided, however, that a person shall not be deemed the beneficial owner of, or to "beneficially own":
 - (i) Securities tendered pursuant to a tender or exchange offer made by such person or any of such person's affiliates or associates until such tendered securities are accepted for purchase or exchange; or
 - (ii) Securities issuable upon exercise of exempt rights; or
- (c) Such person or any of such person's affiliates or associates:
 - (i) Has any agreement, arrangement or understanding (whether or not in writing) with any other person (or any affiliates or associates thereof) that "beneficially owns" such securities for the purpose of acquiring, holding, voting (except as set forth in the proviso to subsection (a) of this definition) or disposing of such securities; or

- (ii) Is a member of a group (as that term is used in Rule 13d-5(b) of the General Rules and Regulations under the Exchange Act) that includes any other person that beneficially owns such securities; provided, however, that nothing in this definition shall cause a person engaged in business as an underwriter of securities to be the beneficial owner of, or to "beneficially own," any securities acquired through such person's participation in good faith in a firm commitment underwriting until the expiration of 40 days after the date of such acquisition. For purposes hereof, "voting" a security shall include voting, granting a proxy, consenting or making a request or demand relating to corporate action (including, without limitation, a demand for a shareholder list, to call a shareholder meeting or to inspect corporate books and records), or otherwise giving an authorization (within the meaning of Section 14(a) of the Exchange Act) in respect of such security.

The terms "beneficially own" and "beneficially owning" shall have meanings that are correlative with this definition of the term beneficial owner.

Change of Control: Shall mean any of the following occurring on or after May 13, 2014:

- (a) Any Person (other than an exempt person) shall become the beneficial owner of 20% or more of the shares of common stock then outstanding or 20% or more of the combined voting power of the voting stock of ConocoPhillips then outstanding; provided, however, that no Change of Control shall be deemed to occur for purposes of this subsection (a) if such person shall become a beneficial owner of 20% or more of the shares of common stock then outstanding or 20% or more of the combined voting power of the voting stock of ConocoPhillips then outstanding solely as a result of (i) any acquisition direction from ConocoPhillips or (ii) any acquisition by a person pursuant to a transaction that complies with clauses (i), (ii) and (iii) of subsection (c) of this definition;

- (b) Individuals who, as of May 13, 2014, constitute the COP Board (the “Incumbent Board”) cease for any reason to constitute at least a majority of the COP Board; provided, however, that any individual becoming a director subsequent to May 13, 2014 whose election, or nomination for election by ConocoPhillips’ shareholders, was approved by a vote of at least a majority of the directors then comprising the Incumbent Board shall be considered as though such individual were a member of the Incumbent Board; provided, further, that there shall be excluded, for this purpose, any such individual whose initial assumption of office occurs as a result of any actual or threatened election contest with respect to the election or removal of directors or other actual or threatened solicitation of proxies or consents by or on behalf of a person other than the COP Board;
- (c) ConocoPhillips shall consummate a reorganization, merger, statutory share exchange, consolidation or similar transaction involving ConocoPhillips or any of its subsidiaries or sale or other disposition of all or substantially all of the assets of ConocoPhillips, or the acquisition of assets or securities of another entity by ConocoPhillips or any of its subsidiaries (a “Business Combination”), in each case, unless following such Business Combination:
 - (i) 50% or more of the then outstanding shares of common stock of the corporation, or common equity securities of an entity other than a corporation, resulting from such Business Combination and the combined voting power of the then outstanding voting stock of such corporation or other entity are beneficially owned, directly or indirectly, by all or substantially all of the persons who were the beneficial owners of the outstanding common stock immediately prior to such Business Combination in substantially the same proportions as their ownership, immediately prior to such Business Combination, of the outstanding common stock;
 - (ii) no person (excluding any exempt person or any person beneficially owning, immediately prior to such Business Combination, directly or indirectly, 20% or more of the common stock then outstanding or 20% or more of the combined voting power of the voting stock of ConocoPhillips then outstanding) beneficially owns, directly or indirectly, 20% or more of the then outstanding shares of common stock of the corporation, or common equity securities of an entity other than a corporation, resulting from such Business Combination or the combined voting power of the then outstanding voting stock of such corporation or other entity; and
 - (iii) at least a majority of the members of the board of directors of the corporation, or the body which is most analogous to the board of directors of a corporation if not a corporation, resulting from such Business Combination were members of the Incumbent Board at the time of the initial agreement or initial action by the COP Board providing for such Business Combination; or
- (d) The shareholders of ConocoPhillips shall approve a complete liquidation or dissolution of ConocoPhillips unless such liquidation or dissolution is approved as part of a transaction that complies with clauses (i), (ii), and (iii) of subsection (c) of this definition.

common stock: Means the common stock, par value \$.01 per share, of ConocoPhillips.

COP Board: Shall mean the Board of Directors of ConocoPhillips or any successor thereto.

Exchange Act: Means the Securities Exchange Act of 1934, as amended.

exempt person: Shall mean any of ConocoPhillips, any entity controlled by ConocoPhillips, any employee benefit plan (or related trust) sponsored or maintained by ConocoPhillips or any entity controlled by ConocoPhillips, and any person organized, appointed or established by ConocoPhillips for or pursuant to the terms of any such employee benefit plan.

exempt rights: Shall mean any rights to purchase shares of common stock or other voting stock of ConocoPhillips if at the time of the issuance thereof such rights are not separable from such common stock or other voting stock (i.e., are not transferable otherwise than in connection with a transfer of the underlying common stock or other voting stock), except upon the occurrence of a contingency, whether such rights exist as of May 13, 2014 or are thereafter issued by ConocoPhillips as a dividend on shares of common stock or other Voting Securities or otherwise.

person: Shall mean any individual, firm, corporation, partnership, association, trust, unincorporated organization or other entity.

voting stock: Shall mean, (i) with respect to a corporation, all securities of such corporation of any class or series that are entitled to vote generally in the election of, or to appoint by contract, directors of such corporation (excluding any class or series that would be entitled so to vote by reason of the occurrence of any contingency, so long as such contingency has not occurred) and (ii) with respect to an entity which is not a corporation, all securities of any class or series that are entitled to vote generally in the election of, or to appoint by contract, members of the body which is most analogous to the board of directors of a corporation.

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Introduction

This section provides you with general information about many ConocoPhillips employee benefit plans. It also provides information you're required to receive under the Employee Retirement Income Security Act of 1974 (ERISA).

What Else You Should Know

Administrative Information

The information in this chapter applies to each of the following plans unless provided otherwise:


- ConocoPhillips Medical and Dental Assistance Plan ("Employee Medical Plan" or "Employee Vision Plan" or "Employee Dental Plan" or "U.S. Inpatient Medical and Dental Plan" or "Expatriate Medical and Dental Plan" or "Houston Onsite Medical Clinic Plan" or "The Well Onsite Medical Clinic Plan");
- ConocoPhillips Flexible Spending Plan ("Flexible Spending Plan");
- ConocoPhillips Disability Plan (including Short-Term Disability (STD) and Long-Term Disability (LTD));
- ConocoPhillips Group Life Plan ("Group Life Plan") (including Life, Accidental Death and Dismemberment (AD&D) and Occupational Accidental Death (OAD) coverage);
- ConocoPhillips Employee Assistance Plan ("Employee Assistance Plan" or "EAP"); and
- ConocoPhillips Severance Pay Plan ("Severance Pay Plan").

On January 1, 2024, the Flexible Spending Plan, ConocoPhillips Disability Plan, Group Life Insurance Plan, EAP, and Severance Pay Plan, along with certain other ConocoPhillips Employee benefit plans, were merged with and into the ConocoPhillips Medical and Dental Assistance Plan. The ConocoPhillips Group Life Insurance Plan was then renamed the ConocoPhillips Group Life Plan and the ConocoPhillips Medical and Dental Assistance Plan was renamed the ConocoPhillips Employee Welfare Benefit Plan (the "Wrap Plan"). For convenience, the word "Plan" is used in this section to refer to the Wrap Plan and any and/or all the component plans that are described in this SPD. Other ConocoPhillips employee benefit plans under the Wrap Plan are described in separate summary plan descriptions.

✓ Only the following sections apply to the ConocoPhillips The Well Onsite Medical Clinic Plan:

- What Else You Should Know
- Your ERISA Rights
- COBRA Continuation Coverage
- USERRA Continuation Coverage
- Claims and Appeals Procedures
- ERISA Plan Information

✓ Please refer to the Glossary beginning on page O-1 for the definitions of underlined terms used throughout this SPD.

 "Glossary," page O-1

✓ If you use **Cigna Global Health Benefits** for health benefits or use **TELUS Health for EAP services**, a separate Certificate of Coverage will be provided to you. The Certificate of Coverage and this SPD, when combined, constitute your Summary Plan Description.

In addition, only the following sections of this chapter apply to your coverage:

- Administrative Information
- Plan Changes or Termination
- Your ERISA Rights
- HIPAA Privacy Rules
- Claims and Appeals Procedures *(with respect to eligibility to participate in the Plan only)*
- ERISA Plan Information

✓ Only the following sections apply to the ConocoPhillips Houston Onsite Medical Clinic Plan:

- What Else You Should Know
- Your ERISA Rights
- Claims and Appeals Procedures
- ERISA Plan Information

Plan Identification Information

The Primary Employer (also the Plan Sponsor) and Identification Number are:

ConocoPhillips Company
925 N. Eldridge Pkwy.
Houston, TX 77079

Employer ID#: 73-0400345

A complete current list of employers participating in the Plan may be obtained at any time, free of charge, from the Benefits Committee.

Plan Administration

The Board of Directors of ConocoPhillips Company has established a Benefits Committee. The Benefits Committee has overall responsibility for the operation and administration of the Plan as indicated in the chart below. The Benefits Committee:

- Is the named fiduciary;
- Has discretionary authority under the Plan;
- Determines all claims and appeals for eligibility to participate in the Plan; and
- Has the power to delegate responsibilities and authority (including discretionary authority) under the Plan. Some responsibilities and authority that may be delegated include reviewing claims and appeals, construing the terms of the Plan and insurance contract (if applicable) under the Plan and signing communications on behalf of the Benefits Committee.


Plan	Plan Administration
ConocoPhillips Medical and Dental Assistance Plan ConocoPhillips Flexible Spending Plan (FSP) ConocoPhillips Disability Plan <i>(Including STD and LTD)</i> ConocoPhillips Group Life Plan <i>(Including Accidental Death and Dismemberment (AD&D) and Occupational Accidental Death (OAD))</i> ConocoPhillips Employee Assistance Plan (EAP) ConocoPhillips Severance Pay Plan	Benefits Committee ConocoPhillips Company P.O. Box 4783 Houston, TX 77210 (918) 661-5381 or (877) 812-7547

Agent for Service of Legal Process

For disputes arising from the Plan, legal process may be served on:

General Counsel (or successor)
ConocoPhillips Company
925 N. Eldridge Pkwy.
Houston, TX 77079

Service of legal process may also be made upon the Benefits Committee or appropriate Claims Administrator (for the insured plans) at the addresses shown for them.

 "Contacts," page A-1

Assignment of Benefits

With the exception of a Qualified Medical Child Support Order or payment of benefits under the Severance Pay Plan as described below, or as the Benefits Committee may otherwise permit by rule or regulation, you cannot assign, either voluntarily or involuntarily your benefits under the Plan. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable under the Plan shall be void and have no effect; nor will any interest in or benefit payable under the Plan be in any way subject to any legal or equitable process, including garnishment, attachment, levy, seizure or lien. Any attempt to assign a benefit will be treated as a direction to pay benefits to a purported assignee rather than as an assignment of rights, and in no way grants a health care provider (or other third party) assignee or beneficiary status under the Plan. For the avoidance of doubt, this anti-assignment prohibits any health care provider or other purported assignee from bringing any claim under ERISA or other Federal or State law or regulation purporting to have an assignment of benefits, and any such attempt to effect such assignment shall be void and unenforceable.

In the Benefits Committee's discretion, it is authorized to permit communications between the Plan and a health care provider (or other third party) under the Plan's claims procedures and pursuant to a purported written assignment of benefits; provided, however, that any such communication shall not act as a waiver of the Plan's anti-assignment provisions, even when this anti-assignment provision is not expressly asserted by the Benefits Committee (or Claims Administrator), and shall not restrict the Plan from asserting such anti-assignment provisions at any time. Except as otherwise agreed by the Plan, in no event shall the Plan, the Company, or its affiliates be liable to any health care provider (or other third party) to whom a Plan participant (or beneficiary) may be liable for medical care, treatment, or other services. Additionally, the Company shall not be liable for, or subject to, the debts contracts, liabilities, engagements or torts of any person entitled to benefits under the Plan.

The benefits provided by the Severance Pay Plan cannot be used as security for a loan. However, Severance Pay Plan benefits are subject to garnishment, attachment or other legal process. If your Severance Pay Plan benefits are garnished or attached by legal process, the Company will pay the garnished or attached amount in accordance with the decree ordering such payment. Neither the Company nor any Plan fiduciary is required to investigate the validity of any decree that appears to be valid on its face. In the event you have an outstanding obligation to the participating employer, you may, with the consent of the Company, assign all or a portion of your benefit to the participating employer to the extent of such obligation.

Qualified Medical Child Support Order (QMCSO)

In general, a QMCSO is a type of court order that gives your biological or legally adopted child the right to participate in your health (medical, vision, dental, EAP, Houston Onsite Medical Clinic, The Well Onsite Medical Clinic and Flexible Spending Plan's Health Care Flexible Spending Account) coverage. For purposes of a QMCSO, your biological or legally adopted child must meet the requirements to be an eligible child under the terms of the health plan.

✓ **Note:** QMCSOs do not apply to your grandchildren, nieces, nephews, stepchildren and/or to children of a domestic partner. The court order must satisfy certain specific conditions under federal law in order to qualify as a QMCSO. The Benefits Committee or its designee will notify you if a medical child support order that applies to you is received and will provide you with a copy of the Plan procedures for determining whether the order qualifies as a QMCSO. You can obtain a copy of these QMCSO procedures by calling the Benefits Center.

 "Contacts," page A-1

Subrogation Rights (Recovery of Benefits Paid)

Employee Medical Plan, the Houston Onsite Medical Clinic Plan and The Well Onsite Medical Clinic Plan

The Employee Medical Plan, the Houston Onsite Medical Clinic Plan and The Well Onsite Medical Clinic Plan (the “Medical Plan”) have certain special rights, called rights of “subrogation” and “recovery” which are described in this section. When you or any of your covered dependents suffer an injury defined as a “condition” below and a “third party” also defined below may be responsible for paying costs associated with that condition, the Medical Plan immediately upon paying or providing any benefits related to that condition will subrogate (stand in the place of) all your rights of recovery up to the full extent of the benefits provided or to be provided by the Medical Plan. The Medical Plan may assert a claim or file suit in your name and take appropriate action to assert the subrogation claim with or without your consent. The Medical Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

✓ As used for this provision:

- “You” and “Your” means you and/or your covered dependent.
 - A “third party” can be:
 - The responsible party which includes anyone who may be responsible in any way for your condition;
 - Any insurance that covers you or a responsible party (insurance including but not limited to liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, Workers’ Compensation coverage, no fault automobile coverage or any first party insurance coverage.
 - A “third party” excludes:
 - ConocoPhillips Company and any other entity that is a sponsoring employer of the Medical Plan.
 - A “condition” includes an injury, illness, sickness or other medical disorder including pain and suffering.
-

The Medical Plan’s rights of subrogation and recovery are described below:

- The Medical Plan may pay (or owe) benefits relating to a condition for which you may be entitled to compensation from a third party. This compensation may include entitlement to payments by that third party to or on your behalf. If this occurs, the Medical Plan is subrogated to all of your rights against, claims against and partial or full recoveries from that third party up to the amount paid (or owed) by the Medical Plan. This is true regardless of whether the Medical Plan actually has paid the benefits described above, and regardless of whether you have been fully compensated or “made whole” for the condition.
- In addition, if you receive a full or partial recovery from a third party relating to a condition, the Medical Plan is entitled to an independent right of immediate and first reimbursement from that recovery (before you or anyone else is paid anything from that recovery), up to the amount paid (or owed) by the Medical Plan for that condition. This is true regardless of whether the Medical Plan actually has paid the benefits described above, regardless of whether you have been fully compensated or “made whole” for that condition, regardless of fault or negligence, and regardless of how you obtained that recovery from the third party (for example, by a settlement agreement, court order or otherwise).
- You’ll be responsible for payment of the legal fees associated with your rights of recovery against a third party. The Medical Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue claims related to your condition. The Medical Plan’s rights of subrogation and reimbursement described in this section apply to all amounts that you recover (rather than the amounts remaining after payment of any legal fees and costs). This is true even if the “common law” provides otherwise. The Medical Plan’s rights of reimbursement and subrogation apply to the first monies that you’re paid or receive, without deductions of any type, including costs or attorney’s fees that you incur in order to obtain a payment from a third party with respect to a condition.
- The Medical Plan may require, before paying any benefits, that you do everything that may be necessary or helpful related to the Medical Plan’s rights described in this section, including signing (or obtaining signatures on) relevant documents. If the covered dependent with the condition is a minor child, the child’s parent or guardian must sign the required documents on behalf of the child. However, the Medical Plan shall have rights to

reimbursement and subrogation described in this section regardless of whether these documents are signed and provided to the Medical Plan. You must do nothing to prejudice (or harm) the Medical Plan's rights to reimbursement and subrogation. If you don't comply with any Medical Plan requirement, the Medical Plan may withhold benefits, services, payment or credits that otherwise may be due under the Medical Plan.

- You must promptly notify (within 30 – 45 days of the filing of a claim with any party for damages resulting from a third party accident) the Benefits Committee of the possibility of obtaining a recovery from a third party for a condition for which the Medical Plan has provided benefits (or may be responsible for providing benefits). This is true regardless of whether that recovery may be obtained by a settlement agreement, court order or otherwise. You must not agree to a settlement regarding that condition without first obtaining the written consent of the Benefits Committee.
- If you do not pursue a claim against a third party, you will be deemed to have assigned to the Medical Plan any benefits or claims or rights of recovery you might have from such third party to the full extent of the Medical Plan's subrogation and reimbursement claims.

If you settle a claim with a third party in a way that results in the Medical Plan being reimbursed less than the amount of Medical Plan benefits related to a condition, or in any way that relieves the third party of future liability for medical costs, the Medical Plan may refuse to pay additional benefits for that condition unless the Benefits Committee previously approved the settlement in writing.

The Medical Plan may enforce its subrogation and reimbursement rights in any of the following ways:

- The Medical Plan may require you to make a claim against any insurance coverage under which you may be entitled to a recovery for a condition.
- The Medical Plan may intervene in any legal action you bring against a third party related to a condition.
- The Medical Plan on its own behalf may pursue legal action against a third party related to a condition.
- The Medical Plan may bring a legal action against (i) you, (ii) the attorney for you or anyone else, and (iii) any trust (or any other party) holding any proceeds recovered by or with respect to you.

The Medical Plan shall have a lien on all amounts recovered related to a condition for which it pays (or may owe) benefits, up to the amount of the Medical Plan obligations. This is true regardless of whether the amounts recovered are obtained by a settlement agreement, court order or otherwise. The lien applies to a recovery from a third party as defined by the Medical Plan. The Medical Plan may seek relief from anyone who receives settlement proceeds or amounts collected from judgments related to the condition. This relief may include, but is not limited to, the imposition of a constructive trust and/or an equitable lien.

If you or any other beneficiary accepts payment from the Medical Plan or has Medical Plan benefits paid on your (or his or her) behalf, that person does so subject to the provisions of the Medical Plan, including the provisions described in this "Subrogation Rights" section.

You acknowledge that the Medical Plan has the right to conduct an investigation regarding any condition to identify potential sources of recovery. The Medical Plan reserves the right to notify all parties and his/her agents of its lien. Agents include but are not limited to, insurance companies and attorneys.

The employer, the Medical Plan, the Benefits Committee and the Claims Administrator also are entitled to recover any amounts paid under the Medical Plan that exceed amounts actually owed under the Medical Plan. These excess Medical Plan payments may be recovered from you, any other persons with respect to whom the payments were made, the person who received the benefit payment, any insurance companies, and any other organization or any other beneficiary of the Medical Plan. The employer, the Medical Plan, the Benefits Committee and/or the Claims Administrator also may, at its option, deduct the amount of any excess Medical Plan payments from any subsequent Medical Plan benefits payable to, or on behalf of, you. The Benefits Committee and/or the Claims Administrator have the authority and discretion to interpret the Medical Plan's recovery provision.

Right of Recovery

For Medical, Vision, Dental, Houston Onsite Medical Clinic and The Well Onsite Medical Clinic Plans

If you are paid more than you should have been reimbursed for a claim, or if a claim is paid for ineligible expenses or ineligible dependents, the Claims Administrator may deduct the overpayment from future claims payments due to you under the ConocoPhillips Medical and Dental Assistance Plan or require the return of the overpayment. If an overpayment is made to a provider, the Claims Administrator can request return of the overpayment or reduce future payments made to that provider by the amount of the overpayment.

For Flexible Spending Plan Reimbursements

If you are reimbursed more than you should have been from your Health Care Flexible Spending Account and/or Dependent Care Flexible Spending Account, the Claims Administrator may deduct the overpayment from future reimbursements or request reimbursement from you directly. Overpayments not returned will be treated as a taxable distribution.

For Long-Term Disability (LTD) Plan

The insurer has the right to recover from you any amount it determines to be an overpayment under the LTD Plan, and you have the obligation to refund any such amount. The insurer's rights and your obligations in this regard also are set forth in the reimbursement agreement you are required to sign when you become eligible for disability benefits under the LTD Plan. This reimbursement agreement:

- Confirms that you will repay all overpayments; and
- Authorizes the insurer to obtain any information relating to any of the items listed in the "Benefit Reductions" section of the LTD chapter of this SPD.

 "LTD Benefit Reductions," page L-10

An overpayment occurs when the insurer determines that the total amount paid by the insurer on your disability claim is more than the total of the benefits due under the LTD Plan. This includes overpayments resulting from:

- Retroactive awards received from sources listed in the "Benefit Reductions" section;
- Fraud; or
- Any error the insurer makes in processing your disability claim.

The overpayment equals the amount the insurer paid in excess of the amount the insurer should have paid under the LTD Plan.

You have a right to appeal any overpayment recovery.

 "Claims and Appeals Procedures," page N-26

An overpayment also occurs when payment is made by the insurer under the LTD Plan when the payment should have been made under another group plan. In that case, the insurer may recover the payment from one or more of the following:

- Any other insurer;
- Any other organization; or
- Any person to or for whom payment was made.

In the case of a recovery from a source other than the LTD Plan, the insurer's overpayment recovery will not be more than the amount of the recovery.

The insurer may, at its option, recover the overpayment by:

- Reducing or offsetting against any future benefits payable under the LTD Plan to you or your survivors;
- Stopping future benefit payments under the LTD Plan (including the minimum benefit) which would otherwise be due under the LTD Plan. LTD Plan benefit payments may continue when the overpayment has been recovered; or
- Demanding an immediate refund of the overpayment from you.

For Short-Term Disability (STD) Plan

If it is determined that the STD Plan has paid more than should have been paid under the STD Plan in error, or the STD Plan has paid short-term disability absence benefits based upon a falsified claim or falsified information, the STD Plan retains the contractual right to recover all excess amounts from the eligible employee, his or her estate, or the person to whom payments were made.

Either the Claims Administrator or the Benefits Committee may:

- Deduct the amount of such overpayment from any subsequent benefits payable to the eligible employee or to other present or future amounts payable under the STD Plan; or
- Recover such amount by any other method that the Claims Administrator or Benefits Committee shall determine.

At the discretion of the Benefits Committee, the eligible employee may be suspended from participation in the STD Plan for the remainder of the current plan year or all future plan years for failure to repay any overpayments or for falsifying a claim for short-term disability absence benefits, including any supporting documentation.

For Severance Pay Plan

An adjustment will be made in an equitable manner to conform to the facts if:

- The Company or its agents or representatives make an error determining eligibility for benefits, calculating benefits or administering the Severance Pay Plan; or
- You or your beneficiary make a misstatement (or fail to state a material fact) in an application or claim for benefits or in response to a request for more information from the Company.

Such adjustments could include a requirement that you or your beneficiary repay part or all of a payment previously made to you or your beneficiary.

Plan Changes or Termination

ConocoPhillips Company, acting through action of its Board of Directors or a delegate of the Board of Directors, may amend, modify, suspend or terminate the Plan (including but not limited to any or all of the component plans under the Plan), in part or in whole, at any time and from time to time.

With regard to the ConocoPhillips Medical and Dental Assistance Plan and Flexible Spending Plan, if the Plan is terminated or benefits are eliminated from the Plan, the Plan will pay benefits for services or supplies that, prior to the date of the benefit elimination or Plan termination, (i) were covered by the Plan, and (ii) were obtained by you or one of your covered dependents. In addition, if the Plan is terminated, COBRA continuation coverage will be offered to the extent required by law. COBRA is not offered for the Houston Onsite Medical Clinic Plan.

 “COBRA Continuation Coverage,” page N-12

With regard to the self-insured options of the Employee Medical Plan and Employee Dental Plan, if the Plan is terminated, any remaining assets that are held will be used for the payment of Plan expenses and benefits that are properly due and payable under the Plan. Any remaining Plan assets may be transferred to a successor Plan or, if no successor Plan is established, may be refunded to Plan participants. In general, no Plan assets may ever revert to the Company.

With regard to the ConocoPhillips Disability Plan and the ConocoPhillips Group Life Plan, if the Plan is terminated or if benefits are eliminated from the Plan, benefits which become payable under the terms of the Plan documents (including any insurance contracts) prior to the date of the benefit elimination or Plan termination will be paid in accordance with the terms of the Plan documents (including any insurance contracts).

With regard to the ConocoPhillips Severance Pay Plan:

- No amendment or modification of the Severance Pay Plan will affect any benefits that may be payable to you if you have satisfied all the eligibility requirements and have become entitled to a payment that has not been paid in full.
- The Severance Pay Plan cannot be amended, terminated, suspended or withdrawn within 24 months after a change of control, except that (i) the Severance Pay Plan can be amended to comply with legal requirements, and (ii) the Severance Pay Plan can be amended to make changes that do not negatively affect eligibility to be a participant in the Severance Pay Plan or participants' eligibility for benefits, amount of benefits or other rights under the Severance Pay Plan. These restrictions apply to the 24 months after the first event that constitutes a change of control. The restrictions lapse at the end of the 24-month period, even if another change of control occurs.

Your ERISA Rights

As a participant in the Plan described in this handbook, you're entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants are entitled to:

- **Receive information about their Plan and benefits, as follows:**
 - Examine, without charge, at the Benefits Committee's office and at other locations (field offices, plants and selected work sites), 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 for review at the Public Disclosure Room of the Employee Benefits Security Administration;
 - Obtain, upon written request to the Benefits Committee, 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 Summary Plan Descriptions. The Benefits Committee may make a reasonable charge for the copies; and
 - Receive a summary of the Plan's annual financial report at no charge (the Plan is required by law to furnish each participant with a copy of this summary annual report).

- **Continue group health plan coverage, as follows:**

- Continue health care (medical, The Well Onsite Medical Clinic, vision, dental and Flexible Spending Plan's Health Care Flexible Spending Account but excludes Houston Onsite Medical Clinic) coverage for yourself, your spouse/domestic partner and/or your dependents, if coverage is lost as a result of a qualifying event. You or your dependents may have to pay for such coverage.

 "COBRA Continuation Coverage," page N-12

Prudent Actions 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 are called "fiduciaries" and have a duty to operate the Plan prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or discriminate against you in any way to prevent you from obtaining benefits under the Plan 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 your rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and don't receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Benefits Committee to provide the materials and pay you up to \$110 a day until you receive the materials, unless they were not sent because of reasons beyond the control of the Benefits Committee.


If you have a claim for benefits which is denied or ignored, in whole or in part, after following the required appeals process, you may file suit in federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If the Plan fiduciaries misuse the Plan's money, or if you're 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're successful, the court may order the person you have sued to pay these costs and fees. If you lose — for example, if the court finds your claim is frivolous — the court may order you to pay these costs and fees.

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- ✓ Any actions related to the Plans for which you can file suit in a federal court must be brought in a federal court in Harris County, Texas.
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✓ For More Information

If you have any questions about the Plan, contact the Benefits Committee or Claims Administrator.

-  “Plan Administration,” page N-4; “Claims Administrators and Appeals Administrators,” page N-28; “Contacts,” page A-1


If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Benefits Committee, 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 N.W., Washington, DC 20210.

You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

✓ The information in this section applies only to the ConocoPhillips Medical and Dental Assistance Plan (excluding coverage provided by the Houston Onsite Medical Clinic Plan and the Expatriate Medical and Dental Plan), the FSP-HCFSA and the Employee Assistance Plan (excluding coverage provided by TELUS Health). An initial notice is furnished to covered employees and spouses/domestic partners at the time their coverage under the applicable group health plan commences, informing them of their rights under COBRA and describing certain provisions of the law.

✓ **For More Information**

Questions concerning the Plan or your COBRA rights should be addressed to the COBRA Administrator or the Benefits Center.

 *"Contacts," page A-1*

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.)

COBRA Continuation Coverage

✓ Domestic partners and domestic partners' children are not eligible for COBRA coverage in the Flexible Spending Plan's Health Care Flexible Spending Account ("FSP-HCFSA"). Within this COBRA Continuation Coverage section, any reference to eligible dependent will not include domestic partners or their children with respect to eligibility for FSP-HCFSA coverage under the Flexible Spending Plan. Domestic partners and their children will be eligible to elect COBRA coverage for the ConocoPhillips Medical and Dental Assistance Plan and Employee Assistance Plan, if they were covered under either Plan prior to a qualifying event.

The "When Coverage Ends" section included in the Employee Medical Plan, Employee Vision Plan, Employee Dental Plan, Employee Flexible Spending Plan and Employee Assistance Plan chapters explains when your or your dependents' coverage would ordinarily end under each Plan. However, under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage for the following benefits may be continued beyond the usual ending dates under the limited circumstances described in this COBRA section:

- Medical coverage, including prescription drugs, the hearing discount program and the vision discount program;
- Vision coverage;
- Dental coverage;
- Flexible Spending Plan — HCFSA only; and
- Employee Assistance Plan (EAP).


✓ Special Considerations in Deciding Whether to Elect COBRA Medical, Vision and/or Dental Coverage (Not Applicable to the FSP-HCFSA or to the Employee Assistance Plan)

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

- Generally, you can be covered for medical, vision and dental coverage under COBRA only until you gain other coverage under another employer group health plan or Medicare. However, COBRA coverage may be allowed if you were enrolled in the other coverage before you became eligible for COBRA coverage under the Plan. If you are eligible for Medicare and enroll in COBRA instead, you may incur a Medicare Part B late enrollment penalty in the future. Contact the COBRA Administrator for information.


 "Contacts," page A-1

- Instead of enrolling in COBRA continuation coverage, there may be other more affordable 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 should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage, you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.
- You always have 60 calendar days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 calendar days, your special enrollment period will end and you may not be able to enroll until the next Marketplace open enrollment period.

 "Qualifying Events & Maximum Duration of COBRA Continuation Coverage," page N-14


Qualifying Events


In general, under COBRA, an individual who was covered by an employer health plan on the day before a qualifying event occurred may be able to elect COBRA continuation coverage upon a qualifying event (such as termination of employment or reduction in hours that causes loss of coverage under the employer health plan). Individuals with such a right are called qualified beneficiaries.

 "Qualifying Events & Maximum Duration of COBRA Continuation Coverage," page N-14

Qualified Beneficiaries

For purposes of COBRA continuation coverage, "qualified beneficiaries" include:

- You and/or any covered dependents that were enrolled in the Plan and lost coverage due to a qualifying event.
 -  "Qualifying Events & Maximum Duration of COBRA Continuation Coverage," page N-14
- Children born to, adopted by or placed for adoption, by you or any qualified beneficiary during the COBRA continuation period.
 - Such a child will be considered a qualified beneficiary as long as you are a qualified beneficiary and have elected COBRA continuation coverage for yourself.
 - The child's COBRA coverage begins when he or she is enrolled in your coverage and lasts for as long as COBRA lasts for your other family members.
 - The child must satisfy the otherwise applicable requirements, such as age, to be an eligible dependent.
- Alternate recipients under QMCSOs.
 - Your child who is receiving benefits under a QMCSO received during your period of employment with the Company has the same COBRA rights as any of your other eligible dependent children.

 "Qualified Medical Child Support Order (QMCSO)," page N-5

✓ **Note:** Each qualified beneficiary can make his or her own independent COBRA election.

Qualifying Events & Maximum Duration of COBRA Continuation Coverage

For the FSP-HCFSA, a qualified beneficiary's coverage can be continued under COBRA until the last day of the **calendar year** in which the qualifying event occurred.

For medical, vision, dental and EAP coverage, the following chart shows how long a qualified beneficiary's coverage can be continued under COBRA based on each qualifying event.

Qualifying Event	Qualified Beneficiaries	Maximum COBRA Period ¹
Your death	Your covered dependents	36 months after loss of coverage due to your death
Termination of your employment for reasons other than gross misconduct	You, your covered dependents and any child born to you, adopted by you or <u>placed for adoption</u> with you during your period of COBRA coverage	18 months after loss of coverage due to your termination date
Reduction in the number of hours you are employed, if there is a loss of coverage under the Plan	You, your covered dependents and any child born to you, adopted by you or <u>placed for adoption</u> with you during your period of COBRA coverage	18 months after loss of coverage due to the reduction in hours
Your failure to return to active employment from a <u>family medical leave of absence (FMLA)</u>	You, your covered dependents and any child born to you, adopted by you or <u>placed for adoption</u> with you during your period of COBRA coverage	18 months after the last day of the <u>leave of absence</u> regardless of whether or not you continued coverage during <u>FMLA</u> leave
You or an <u>eligible dependent</u> become <u>disabled</u> during the first 60 days of COBRA continuation coverage and disability continues at least until the end of the original continuation period ²	You, your covered dependents and any child born to you, adopted by you or <u>placed for adoption</u> with you during your period of COBRA coverage	Coverage can be extended for all qualified beneficiaries from the original 18-month period to 29 months, provided you notify the COBRA Administrator within 60 days after the latest of 1) date of the Determination of Disability by the Social Security Administration (SSA); ³ or 2) qualifying event date; or 3) date qualified beneficiary actually loses coverage and before the end of the 18-month COBRA continuation period. If the notification does not occur in a timely manner, there will be no disability extension of COBRA continuation coverage
Your divorce or legal separation ⁴	Your spouse and other affected covered dependents	36 months after loss of coverage due to the divorce or legal separation
You become enrolled in Medicare coverage less than 18 months before your initial qualifying event (termination of employment or reduction in hours) and you lost coverage under the Plan due to the initial qualifying event ⁵	Your covered dependents	36 months after your enrollment in Medicare
Your dependent child, <u>domestic partner</u> or <u>domestic partner's</u> children no longer meet eligibility requirements ⁶	The affected covered dependent	36 months after loss of coverage due to the change in <u>eligible dependent</u> status

Please see the footnotes on page N-15.

¹ Regardless of the number of qualifying events, the maximum COBRA continuation coverage is 36 months. For example, you and your spouse have 18 months of COBRA coverage due to your termination of employment. Your spouse becomes disabled, thereby extending the original 18 months to 29 months, if proper notice was given. Also, at month 24, if you and your spouse divorce, your spouse's COBRA continuation period only may be extended to 36 months.

² Extension of continuation coverage is available only where the qualifying event was your termination of employment or reduction of hours.

³ If you or another disabled family member recovers from the disability between the 19th and 29th month disability extension, you must notify the COBRA Administrator. The extension of coverage will end with recovery from the disability.

⁴ If a covered employee cancels coverage for his or her spouse in anticipation of divorce or legal separation, and a divorce or legal separation later occurs, the divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Benefits Center within 60 days after the divorce or legal separation and can show that the employee cancelled the coverage earlier in anticipation of divorce or legal separation, COBRA continuation coverage may be available for the period after the divorce or legal separation.


⁵ COBRA continuation coverage can only be continued for qualified beneficiaries (other than the employee) up to 36 months after the date the covered employee becomes enrolled in Medicare. The covered employee's maximum COBRA continuation period will be 18 months. This COBRA continuation coverage period is available only if the covered employee becomes enrolled in Medicare within 18 months before his or her termination or reduction in hours.

⁶ In this section, "domestic partner" means the domestic partner of the covered employee and "child" (with respect to the domestic partner) means the domestic partner's eligible child. Both the domestic partner and the domestic partner's eligible child must be covered under the Plan at the time the qualifying event occurs in order for COBRA rights to apply to the domestic partner's eligible child.

✓ If the qualified beneficiary is determined by the SSA to no longer be disabled, you must notify the COBRA Administrator.

Second Qualifying Event Extension of COBRA Continuation Coverage (Not Applicable to the FSP-HCFSA)

An extension of COBRA continuation coverage is available to spouses, domestic partners, dependent children and domestic partner's children who are receiving COBRA continuation coverage if a second qualifying event occurs during the 18 months (or in the case of a disability extension, the first 29 months) following your termination of employment or reduction of hours. The maximum extension when a second qualifying event occurs is to a total of 36 months of COBRA coverage.

 "Qualifying Events & Maximum Duration of COBRA Continuation Coverage," page N-14

- Second qualifying events include the death of a covered employee, divorce or legal separation from the covered employee or a dependent child ceasing to meet the eligibility requirements for benefit coverage.
- These events will be considered a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (The extension is not available if a covered employee becomes enrolled in Medicare after terminating employment.)
- If the COBRA Administrator is not notified of the second qualifying event in a timely manner, there will be no extension of COBRA coverage due to the second qualifying event.

Your COBRA enrollment materials will include more information about second qualifying event extensions.

Upon the occurrence of a second qualifying event, you must notify the COBRA Administrator within 60 days after the later of:

- The date of the second qualifying event; or
- The date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

If the notice of the second qualifying event is not provided to the COBRA Administrator within the required 60-day period, THERE WILL BE NO EXTENSION OF COBRA CONTINUATION COVERAGE DUE TO A SECOND QUALIFYING EVENT.

Initial Election of COBRA Continuation Coverage by a Qualified Beneficiary

- ✓ You can elect COBRA continuation coverage only for the options in which you were enrolled on the date your coverage ended, not the date of COBRA notification or enrollment. You can add or cancel any dependents on your initial election (new dependents will be considered non-qualified beneficiaries).
-

Here are the steps that need to be taken in order to elect COBRA continuation coverage:

- ConocoPhillips will notify the Plan if you die, your employment ends or your hours are reduced. Neither you nor your representative (in the event of your death) needs to notify the Benefits Center if any of these qualifying events occurs.
- You and/or your covered dependents are responsible for notifying the Benefits Center of a divorce, legal separation or a child losing dependent status while covered under the Plan so COBRA enrollment can be initiated.

 “Contacts,” page A-1

- Notify the Benefits Center within 60 days after the later of (i) the date of one of these qualifying events, or (ii) the date on which coverage would be lost as a result of one of these qualifying events. **If the Benefits Center is not notified during the 60-day period, you and your qualified beneficiaries will lose the right to elect COBRA continuation coverage. You will not be able to elect it later.**
- ConocoPhillips will instruct the COBRA Administrator to notify each qualified beneficiary of their right to elect COBRA continuation coverage and provide them with election instructions.
- To elect COBRA continuation coverage, you and/or your qualified beneficiary must complete the election process with the **COBRA Administrator within 60 days after the date of the COBRA Enrollment Notice (or 60 days after Plan coverage is lost, if later)**. When you complete the COBRA election, you must indicate if any qualified beneficiary is enrolled in Medicare (Part A, Part B or both) and, if so, the date of the Medicare enrollment. (This doesn’t apply if you are enrolling only in the FSP-HCFSA.)

- **If a COBRA election is not made during the 60-day period, you and your qualified beneficiaries will lose the right to elect COBRA continuation coverage. You will not be able to elect it later.**

- For each qualified beneficiary who timely elects COBRA continuation coverage, the coverage will begin on the date that their previous Plan coverage would otherwise have been lost.

- ✓ If you reject COBRA continuation coverage before the end of the 60-day election period and then change your mind, you can still elect COBRA coverage by making an election with the COBRA Administrator **before the end of the election period**.
-

Annual Enrollment Period (Not Applicable to the FSP-HCFSA)

Each year, if you are enrolled in COBRA continuation coverage, you will have the opportunity to elect, change or drop coverage for the following plan year. You can enroll in an option you were eligible for but declined at your initial COBRA enrollment. This is called the “annual enrollment period.” Enrollment limitations may exist and will be communicated to you at annual enrollment. You also may add or drop dependents during the annual enrollment period. You may change or elect coverage only during the designated annual enrollment period each year. Otherwise you must wait until the next annual enrollment period to elect or change coverage.

HIPAA SPECIAL ENROLLMENT

(Applies only to enrollment in medical coverage)

If you are declining enrollment for your eligible dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll your eligible dependents in the Plan if your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your dependents’ other coverage and you can no longer afford the coverage).

In addition, if you have previously declined coverage and gain a new eligible dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your eligible dependents.


To request special enrollment or obtain more information, contact the COBRA Administrator.


 “Contacts,” page A-1

Enrollment Changes During COBRA Continuation Coverage Period

Each qualified beneficiary must notify the COBRA Administrator of dependent changes that occur while the dependent is enrolled in COBRA continuation coverage. Dependent coverage that is added cannot last beyond the period of the qualified beneficiary’s COBRA continuation coverage. Check with the COBRA Administrator prior to adding dependents because rules may vary depending on your employment status on the event date. Coverage cancellations for you and/or your dependent(s) can be made at any time.

Other than during each year’s annual enrollment, you can change your coverage election only if you experience a change in status for which you may be required or allowed to make changes to your coverage. The coverage election must be consistent with your change in status, and you cannot make a coverage change for financial reasons or because a provider stops participating in a network. Refer to the “Changing Your Coverage” section in the medical, vision, dental and/or FSP chapters of this handbook for further information about a change in status and timeframes.

 “Changing Your Coverage,” page B-9, E-7, F-7 and/or G-6

 You must notify the Benefits Center of address changes and changes to your marital status or dependents.

 “Contacts,” page A-1

Paying for COBRA Continuation Coverage

The cost of COBRA continuation coverage is the full cost (including both employee and employer costs) to provide the benefit plus a 2% administrative fee, for a total cost of 102%. The amount due for each month for each qualified beneficiary will be disclosed in the COBRA election notice provided to you at the time of your qualifying event for the remainder of the plan year. The cost to be paid for COBRA continuation coverage may change from time to time during your period of COBRA continuation coverage and may increase over time.

If coverage is being continued due to disability, the cost during months 19 through 29 is 150% of the full cost of coverage.

Your payments must be sent to the COBRA Administrator.

- **First payment** — You must make your first payment within 45 days after the date of your election. This payment must cover your costs from the date you lost coverage up to the time you make your payment. You may elect to make monthly payments either by check or automatic deductions from your bank account.
- **Remaining monthly payments** — The payment for each month's coverage is due on the first day of the month. You'll be given a grace period of 30 days to make monthly payments. If you make a monthly payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the monthly payment is received within the 30-day grace period.

Checks that are returned unpaid from a bank for any reason will result in untimely payment and result in cancellation of coverage. Partial payments will not be accepted and will be treated as non-payment, which will result in cancellation of coverage.

Your COBRA enrollment materials will contain detailed information about payment methods and unacceptable payments for COBRA coverage. **If you don't make payments as required in this COBRA Continuation Coverage section or in your COBRA enrollment materials, you will lose all COBRA rights under the Plan, and claims for expenses incurred after your coverage ends will not be paid by the Plan.**

If you have any questions, contact the COBRA Administrator.

 *"Contacts," page A-1*

Enrolled in COBRA and in Another Company's Plan or Medicare

- ✓ This section applies to continued medical coverage under COBRA only. It doesn't apply to dental, vision or Employee Assistance Plan coverage or the Flexible Spending Plan's Health Care Flexible Spending Account participation.

You may enroll in both the COBRA continuation coverage under the Employee Medical Plan and in group health coverage under a different employer. However:

- If you elect COBRA continuation coverage under the Employee Medical Plan first and then become covered (enrolled) in the Company's or another group health plan or enroll in Medicare (Part A, Part B or both), the Company will reserve the right to cancel your COBRA continuation coverage. This rule does not apply if you enroll in the Company's Retiree Medical Age 65 and Over Plan. In addition, you must notify the COBRA Administrator when any qualified beneficiary becomes covered under another group health plan or enrolls in Medicare Part A, Part B or both. The Benefits Committee may require repayment to the Plan of all benefits paid after the coverage termination date, regardless of whether and when you provide notice to the COBRA Administrator of commencement of other group health plan coverage.

📖 "Contacts," page A-1; "Coordination With Medicare," page B-49; "When COBRA Continuation Coverage Ends," at right

- If you elect coverage under a different employer's group health plan **first** and then COBRA continuation coverage under the Employee Medical Plan, you may have both coverages — if you are willing to pay for both plans. If you elect to continue both COBRA under the Employee Medical Plan and coverage under the other group health plan, then the other group health plan will be the "primary" plan for coordination of benefits.

- If you are enrolled in Medicare (Part A, Part B or both) prior to electing COBRA continuation coverage under the Employee Medical Plan, Medicare coverage will be primary while you are enrolled in COBRA continuation coverage. In this case, when you complete the COBRA election process, you must indicate if any qualified beneficiary is enrolled in Medicare (Part A, Part B or both) and, if so, the date of the Medicare enrollment.

When COBRA Continuation Coverage Ends

COBRA continuation coverage usually ends when the maximum period expires as discussed earlier in this section.


📖 "Qualifying Events & Maximum Duration of COBRA Continuation Coverage," page N-14

However, a qualified beneficiary's COBRA coverage (and the COBRA coverage for anyone covered as that person's dependent) may end before the end of the maximum COBRA coverage period on the earliest of the following dates:

- On the date the qualified beneficiary first obtains coverage under another group health plan¹;
- On the date the qualified beneficiary first becomes enrolled in Medicare benefits under Part A, Part B or both (not applicable to the FSP-HCFSA)¹;
- On the date that the Company ceases to provide any group health plan coverage to any employee;

¹ This applies only if the coverage under the other group health plan or Medicare entitlement begins **after** the date that COBRA continuation coverage is elected under the Plan; contact the COBRA Administrator for information.

📖 "Contacts," page A-1

- On the date the qualified beneficiary fails to pay the full monthly COBRA contribution for continuation coverage on a timely basis;
 “Paying for COBRA Continuation Coverage,” page N-18
- If coverage was extended to 29 months due to disability, the date a determination was made by the Social Security Administration (SSA) that the qualified beneficiary was no longer disabled². You must notify the COBRA Administrator that you are no longer disabled (not applicable to the FSP-HCFSA);
- On the date coverage is terminated for any reason the Plan would terminate coverage for a non-COBRA Plan participant; and
- For the FSP-HCFSA, on the last day of the plan year.

² If the Social Security Administration’s (SSA) determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA continuation coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administrations’ (SSA) determination that the qualified beneficiary is no longer disabled. The Benefits Committee will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice to the COBRA Administrator that the disabled qualified beneficiary is no longer disabled.

- ✓ The COBRA Administrator must be notified when a qualified beneficiary becomes covered under another group health plan or becomes enrolled in Medicare Part A, Part B or both.

 “Contacts,” page A-1

USERRA Continuation Coverage

- ✓ The information in this section applies to the ConocoPhillips Medical and Dental Assistance Plan, Flexible Spending Plan’s Health Care Flexible Spending Account and Employee Assistance Plan (excluding coverage provided by TELUS Health and the Houston Onsite Medical Clinic Plan) only.

Under the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA), the Company must offer you temporary extension of health coverage (medical, vision, dental, Flexible Spending Plan’s Health Care Flexible Spending Account (FSP-HCFSA) and Employee Assistance Plan) for you and your covered dependents at group rates in certain instances where coverage would not otherwise be available under the Plan.

- ✓ **Note:** Under USERRA, unlike COBRA, dependents do not have a separate election right.

If you are covered by the Plan and are placed on military leave of absence (up to 12 months), you will automatically continue coverage at the same rates as active employees. No election is required. If you are covered by the Plan and your military leave of absence ends with the Company (your employment ends), but you are still serving in the uniformed services, you can elect military absence COBRA continuation of coverage (USERRA continuation coverage) until the earlier of 24 months or the date you fail to apply for or return to employment as an employee of the Company. FSP-HCFSA participation can continue only until the end of the calendar year of your termination date. You (or your authorized representative) may elect to continue your coverage under the Plan for yourself and your covered dependents by making an election with the COBRA Administrator and by paying the applicable cost for your coverage. The election must be done within 60 days of the later of the date of the COBRA Enrollment Notice or the date the coverage ends.

If you fail to make an election or do not make your payment within the required timeframe, you will lose your USERRA continuation rights under the Plan except in the case where your failure to give advance notice of service was excused under USERRA because it was impossible, unreasonable, or precluded by military necessity. In that case, the Plan will reinstate your coverage retroactively upon your election to continue coverage and payment of all unpaid amounts due.

Your USERRA continuation coverage cost is 102% of the full costs (including both employer and employee costs). Payments must be sent to the COBRA Administrator. You must make your first payment within 45 days after the date of your election. This payment must cover your costs up to the time you make your payment. Thereafter, the cost for each month's coverage is due on the first day of the month. You will be given a grace period of 30 days to make these subsequent monthly payments. However, if you make a monthly payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the monthly payment is received within the 30-day grace period.

If you elect to continue coverage under USERRA, the USERRA continuation coverage may be continued for up to 24 months. However, coverage will end earlier, if one of the following events takes place:

- You fail to make a payment within the required time;
- You fail to return to work within the time required under USERRA following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other undesirable conduct specified in USERRA.

COBRA and USERRA continuation coverage are concurrent for the first 18 months. This means that both COBRA and USERRA continuation coverage begin when your military leave of absence with the Company ends (your employment ends), and you are still serving in the uniformed services. However, COBRA coverage terminates at the end of 18 months and USERRA continuation coverage terminates at the end of 24 months, unless coverage is terminated earlier due to non-payment of costs or another permitted event described earlier.

You must apply for employment or return to employment within the period required under USERRA for benefit reinstatement. If you cancelled your Plan coverage while on military service, it will be reinstated after your return to work. If you return to work from military service during the same calendar year, you will be re-enrolled automatically in the same coverage options that you had before the leave began. If you return to work from military service in a different year, you can change your options.

HIPAA Privacy Rules


✓ The information in this section applies to the ConocoPhillips Medical and Dental Assistance Plan (excludes the Houston Onsite Medical Clinic Plan and The Well Onsite Medical Clinic Plan), the Flexible Spending Plan's Health Care Flexible Spending Account and the Employee Assistance Plan only (collectively referred to as the "Plan" in this HIPAA Privacy section).

✓ **Genetic Information Nondiscrimination Act:** The Employee Medical Plan, Employee Vision Plan, Employee Dental Plan and Employee Assistance Plan do not collect or use genetic information, including family medical history, to determine eligibility for enrollment or for underwriting purposes. These Plans do not require genetic testing and will not use genetic information to determine premium or contribution amounts.

Use and Disclosure of Protected Health Information

The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the privacy standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. PHI is information that may identify you and that relates to (a) your past, present, or future physical or mental health or condition or (b) the past, present or future payment for your health care.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities may include, but are not limited to, the following:

- Determination of eligibility, coverage and cost-sharing amounts (for example, cost of a benefit, Plan maximums and copays determined for an individual's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals under the claims procedures and other payment disputes);
- Subrogation of health benefit claims;
 "Subrogation Rights (Recovery of Benefits Paid)," page N-6
- Establishing employee and retiree contributions;
- Risk-adjusting amounts due based on enrollee health status (looked at in aggregate and not individually) and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Medical necessity reviews or reviews of appropriateness of care or justification of charges;
- Utilization review, including pre-authorization, concurrent review and retrospective review;
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of provider and/or health plan); and
- Reimbursement to the Plan.

Health care operations may include, but are not limited to, the following activities:

- Quality assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- Business management and general administrative activities of the Plan, including, but not limited to:
 - Management activities relating to the implementation of and compliance with HIPAA’s administrative simplification requirements, also known as privacy requirements; or
 - Customer service, including the provision of data analyses for the Plan Sponsors, policyholders or other customers;
- Resolution of internal grievances; and
- Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a “covered entity” under HIPAA or, following completion of the sale or transfer, will become a covered entity.

The Plan Will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Beneficiary

With an authorization by the participant or beneficiary (that is, you or your covered dependent), the Plan will disclose PHI to whatever entity is set forth in the authorization, including a customer service representative, disability plans, reciprocal benefit plans, Workers’ Compensation insurers for purposes related to administration of those plans and programs.

A Plan representative will be able to assist participants and beneficiaries with an aspect of a claim he or she may have under the Plan only if the participant or beneficiary provides the representative with written permission. The Plan representative will request that you complete and sign an “Authorization for Release of Information.” In the authorization, you will give the representative permission to interface with the Plan and third-party administrator on your behalf. The Plan representative will not handle disputes with providers; therefore, authorization forms will not be accepted except under rare and limited circumstances.

For Purposes of this Section, ConocoPhillips Company is the Plan Sponsor

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan document has been amended to incorporate the following provisions, of which the Plan Sponsor has provided such certification.

With Respect to PHI, the Plan Sponsor Agrees to Certain Conditions

The Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- Not use genetic information for underwriting purposes in compliance with the Genetic Information Nondiscrimination Act of 2008 (GINA);
- Ensure that any agents, including a subcontractor, to whom Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by a participant or beneficiary or a personal representative of the participant or beneficiary;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the participant, beneficiary or his or her respective personal representative, unless such plan is part of the organized health care arrangement that the Plan is a part of, as described below;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to a participant, beneficiary or his or her respective personal representative in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for purposes of determining the Plan's compliance with HIPAA;
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and

- Notify individuals or the HHS Secretary, as necessary, of a breach of unprotected PHI within 60 days of discovery in accordance with HIPAA. Notices will contain a description of the breach (what happened, date of the breach and date of discovery; a list of the types of information involved; suggested steps for the individual's protection; a description of the investigation, mitigation and protection for the future; and contact procedures for more information).

Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

- **For medical, vision and dental coverage and the Flexible Spending Plan HCFSAs (FSP-HCFSAs):**
 - Sr. Vice President of Human Resources & REFS;
 - General Manager, Compensation & Benefits;
 - Manager, U.S. Benefits;
 - Staff designated by the Manager, U.S. Benefits;
 - HIPAA Privacy Officer;
 - HIPAA Security Officer;
 - Staff designated by the HIPAA Privacy Officer;
 - Benefits Committee members;
 - Staff designated by the Benefits Committee;
 - Employee Data Management Staff of HR Shared Services;
 - General Manager, Health Services & CMO;
 - EAP Manager;
 - Chief Information Security Officer;
 - Security Staff designated by the Chief Information Security Officer;
 - Executive Administrative Assistant to the Sr. Vice President of Human Resources & REFS;
 - Employee Benefits Counsel; and
 - Employee Benefits Counsel's legal and administrative assistant(s).

- **For the Employee Assistance Plan**, in accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:
 - Benefits Committee members;
 - Staff designated by the Benefits Committee;
 - EAP Manager;
 - General Manager, Health Services & CMO;
 - Chief Information Security Officer;
 - IT Security Staff designated by the Chief Information Security Officer;
 - Employee Benefits Counsel; and
 - Employee Benefits Counsel’s legal and administrative assistant(s).

Limitations of PHI Access and Disclosure

The persons described in the section immediately above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If the persons named above do not comply with the rules for use and disclosure of PHI, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary action up to and including termination of employment.

Organized Health Care Association

The ConocoPhillips Medical and Dental Assistance Plan, the ConocoPhillips Flexible Spending Plan and the ConocoPhillips Employee Assistance Plan have been designated as part of an “organized health care association” in order to share certain PHI related to treatment, payment and health care operations under the respective plans, lifetime maximums, deductibles and disenrollment from one plan and enrollment to another plan due to open enrollment, relocation or similar circumstances.

HIPAA Security Requirements Applicable to Electronic PHI

The Plan Sponsor will:

- Implement safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
- Ensure that the adequate separation between the Plan and Plan Sponsor, with respect to electronic PHI, is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement the provisions of HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH); and
- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

For more information regarding HIPAA Privacy and the Plans, please contact the Benefits Center or see Notice of Privacy Practices on hr.conocophillips.com.

 “Contacts,” page A-1

Claims and Appeals Procedures

✓ **Note:** The information in this section does not apply to the U.S. Inpatient Medical and Dental Plan, Expatriate Medical and Dental Plan and the Employee Assistance Plan coverage provided by TELUS Health, except for appeals on eligibility to participate in the Plan. Those plans have their own procedures, which will be communicated by the [Claims Administrator](#). Also, those in the Expatriate Medical and Dental Plan and eligible for the U.S. Improvement Plan provisions of the Employee Medical Plan are eligible for a medical claim appeal and the voluntary [external review](#) process regarding an incentive payroll credit.

Reference to FSP in this Claims and Appeals section applies only to the FSP-Health Care Spending Account (HCFA) and the FSP-Dependent Care Flexible Spending Account (DCFA).

The “How to File a Claim” section in each of the health and welfare plan chapters of this SPD describes the steps you need to take in order to file a claim for that Plan’s benefits. **Be sure to keep copies of any documents you send to a [Claims Administrator](#), [Appeals Administrator](#) or the Benefits Committee.**

The information in this section explains the claims and appeals procedures. The procedures include the required response time for a benefit claim or a claim for eligibility and the rules that you must follow if you want to:

- Appeal any denial of a benefit claim by the Plan;
- Appeal a denial of eligibility to participate in the Plan;
- Request an [external review](#) of a denied claim or appeal (excludes the Houston Onsite Medical Clinic Plan);
- Appeal a reduction or termination of a Plan benefit; or
- Sue in federal court regarding a benefit claim.

✓ Designating an Authorized Representative

You may designate someone else to file a claim or appeal on your behalf under the Plan. The purpose of appointing an “authorized representative” is to relieve you or your beneficiary of the burden of completing claims paperwork by yourself; for example, if you are incapacitated due to a medical condition or for any other reason. For this person to be considered your “authorized representative,” one of the following requirements must be satisfied:

- You have given express written consent for the person to represent your interests;
- The person is authorized by law to give consent for you (e.g., parent of a minor, legal guardian, foster parent, power of attorney);
- **For [pre-service](#) and [urgent care claims](#) the person may be:**
 - Your immediate family member (e.g., spouse, parent, child, sibling); or
 - Your primary caregiver; or
 - Your health care professional who knows your medical condition (e.g., your treating physician); or
- **For [outpatient concurrent care claims](#) the person may be:**
 - Your immediate family member (e.g., spouse, parent, child, sibling); or
 - Your primary caregiver; or
- **For [inpatient concurrent care claims](#),** the person may be a health care professional who knows your medical condition (e.g., your treating [physician](#)); or
- For [post-service claims](#) from health care providers, the health care provider (or an employee or representative of the provider) will only be recognized as your designated representative under the terms of a properly executed Authorized Representative Form provided by the Plan or its delegate and has satisfied any other procedures for recognition as an authorized representative that the Benefits Committee may determine.

(continued)

✓ Designating an Authorized Representative *(continued)*

The Plan reserves the right to reject the appointment of an individual or entity as an authorized representative at any time. The Plan may reject an authorized representative appointment if the Plan determines the individual or entity has engaged in practices or activities that violate the Plan's terms or that attempt to modify or effectively circumvent, without the Benefits Committee's express approval, the Plan's requirements with respect to cost sharing. The Plan may also reject an authorized representative appointment if it would contravene or effectively circumvent any of the Plan's anti-assignment provisions. The Plan's acceptance of an authorized representative appointment shall not act as a waiver of a Plan's anti-assignment of benefits provisions and shall not restrict a Plan from asserting such anti-assignment provisions at any time, regardless of whether the Plan has previously communicated with the individual or entity without challenging the individual's or entity's status as authorized representative.



"Contacts," page A-1

If you don't file an appeal within the required timeframes (as shown on page N-35), you'll lose the right to file suit in federal court under ERISA. If you do not file suit in federal court within the timeframes described below, your right to bring such a legal or equitable action will be waived in full.

- **For medical, vision, dental, FSP, EAP, Houston Onsite Medical Clinic and The Well Onsite Medical Clinic claims**, you can't sue in federal court until the second level of appeal is complete and you have exhausted the Plan's administrative remedies. Your suit must be filed within three years of the date of service for the benefit claim in dispute. For medical claims, if the Claims Administrator or Appeals Administrator does not follow the claims and appeals procedures outlined on page N-26, you can request an external review or file suit prior to exhausting the entire process.
- **For life (including OAD), AD&D and LTD claims**, you can't sue in federal court before 60 calendar days after proof of loss was submitted. Your suit must be filed within three years¹ from when proof of loss was required.
- **For STD claims**, you can't sue in federal court until the first level of appeal is complete. Your suit must be filed within three years from the date of the Benefits Committee's final decision to deny the claim. For disability claims, if the Claims Administrator or Appeals Administrator does not follow the claims and appeals procedures outlined in this section, you can file suit prior to exhausting the entire process.
- **For Severance Pay Plan claims**, you can't sue in federal court until the date of the final decision by the Benefits Committee to deny the claim. Your suit must be filed within two years from the date of the Benefits Committee's final decision.

¹ If the law of the state in which you live makes the three-year limit void, the action must begin within the shortest time period permitted by law.

Claims Administrators and Appeals Administrators

In the following procedures you'll find references to the "[Claims Administrator](#)" and "[Appeals Administrator](#)." These roles vary, depending on the type of benefit involved. The following chart shows the designated [Appeals Administrator\(s\)](#) for each type of benefit. These administrators are responsible for handling your appeals.

For a complete listing of [Claims Administrators](#) for all benefit options, see the "Contacts" section.

 "[Contacts](#)," page A-1

Type of Benefit	Appeals Administrator — First Level	Appeals Administrator — Second Level
Employee Medical Plan		
Eligibility to Participate (includes eligibility for a disabled child)	N/A (<i>only one level of appeal is provided, and it's with the Appeals Administrator shown at right</i>)	
Medical Options	Appeals Coordinator Blue Cross and Blue Shield of Texas Medical Claims Administrator P.O. Box 660044 Dallas, TX 75266-0044 (800) 521-2227	ConocoPhillips Company Benefits Committee P.O. Box 4783 Houston, TX 77210 (918) 661-5381 or (877) 812-7547
U.S. Health Improvement Incentive Program	N/A (<i>only one level of appeal is provided, and it's with the Appeals Administrator shown at right</i>)	
Outpatient Prescription Drug Note: Caremark, Inc. administers both first and second level appeals for prescription drug urgent care claim appeals.	Rx Claims Administrator CVS Caremark™ Appeals Department MC 109 P.O. Box 52084 Phoenix, AZ 85702-2084	
Houston Onsite Medical Clinic and The Well Onsite Medical Clinic Plans		
Eligibility to Participate	N/A (<i>only one level of appeal is provided, and it's with the Appeals Administrator shown at right</i>)	Manager, U.S. Benefits ConocoPhillips Company 925 N. Eldridge Pkwy. Houston, TX 77079
Clinic Services	Manager, U.S. Benefits ConocoPhillips Company 925 N. Eldridge Pkwy. Houston, TX 77079	General Manager, Health Services & CMO ConocoPhillips Company 925 N. Eldridge Pkwy. Houston, TX 77079
Employee Vision Plan		
Eligibility to Participate (includes eligibility for a disabled child)	N/A (<i>only one level of appeal is provided, and it's with the Appeals Administrator shown at right</i>)	ConocoPhillips Company Benefits Committee P.O. Box 4783 Houston, TX 77210 (918) 661-5381 or (877) 812-7547
Vision Base and Vision Plus Options	Claims Administrator Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670	Claims Administrator Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195

(continued)

Type of Benefit	Appeals Administrator — First Level	Appeals Administrator — Second Level
Employee Dental Plan		
Eligibility to Participate (includes eligibility for a <u>disabled</u> child)	N/A (only one level of appeal is provided, and it's with the <u>Appeals Administrator</u> shown at right)	ConocoPhillips Company Benefits Committee P.O. Box 4783 Houston, TX 77210 (918) 661-5381 or (877) 812-7547
Dental Coverage	MetLife ConocoPhillips Dental Claims P.O. Box 981282 El Paso, TX 79998-1282 (888) 328-2166	
Flexible Spending Plan		
Eligibility to Participate	N/A (only one level of appeal is provided, and it's with the <u>Appeals Administrator</u> shown at right)	ConocoPhillips Company Benefits Committee P.O. Box 4783 Houston, TX 77210 (918) 661-5381 or (877) 812-7547
Health Care Flexible Spending Account or Dependent Care Flexible Spending Account Claims for Benefits	Inspira Financial Appeals Administrator P.O. Box 4000 Richmond, KY 40476-4000 (888) 678-8242	
Employee Assistance Plan		
Eligibility to Participate (all participants)	N/A (only one level of appeal is provided, and it's with the <u>Appeals Administrator</u> shown at right)	ConocoPhillips Company Benefits Committee P.O. Box 4783 Houston, TX 77210 (918) 661-5381 or (877) 812-7547
EAP (excluding coverage provided by TELUS Health)	Concern 2490 Hospital Dr., Suite 310 Mountain View, CA 94040 (800) 344-4222	ConocoPhillips Company Benefits Committee P.O. Box 4783 Houston, TX 77210 (918) 661-5381 or (877) 812-7547
Disability Plans		
Short-Term Disability (STD)	N/A (only one level of appeal is provided, and it's with the <u>Appeals Administrator</u> shown at right)	ConocoPhillips Company Benefits Committee P.O. Box 4783 Houston, TX 77210 (918) 661-5381 or (877) 812-7547
Long-Term Disability (LTD)	N/A (only one level of appeal is provided, and it's with the <u>Appeals Administrator</u> shown at right)	The Hartford P.O. Box 14868 Lexington, KY 40512 (888) 301-5615

(continued)

Type of Benefit	Appeals Administrator — First Level	Appeals Administrator — Second Level
Life and AD&D Plans		
Life (including Basic Life, Supplemental Life and Dependent Life)	N/A (only one level of appeal is provided, and it's with the <u>Appeals Administrator</u> shown at right)	The Hartford Group Life/AD&D Claims Unit P.O. Box 2999 Hartford, CT 06104-2999 (888) 563-1124
Accidental Death and Dismemberment (excluding Travel Assistance)	N/A (only one level of appeal is provided, and it's with the <u>Appeals Administrator</u> shown at right)	The Hartford Group Life/AD&D Claims Unit P.O. Box 2999 Hartford, CT 06104-2999 (888) 563-1124
Accidental Death and Dismemberment — Travel Assistance Only	N/A (only one level of appeal is provided, and it's with the <u>Appeals Administrator</u> shown at right)	ConocoPhillips Company Benefits Committee P.O. Box 4783 Houston, TX 77210 (918) 661-5381 or (877) 812-7547
Occupational Accidental Death Coverage	N/A (only one level of appeal is provided, and it's with the <u>Appeals Administrator</u> shown at right)	ConocoPhillips Company Benefits Committee P.O. Box 4783 Houston, TX 77210 (918) 661-5381 or (877) 812-7547
Severance Pay Plan		
Severance Pay Plan	N/A (only one level of appeal is provided, and it's with the <u>Appeals Administrator</u> shown at right)	ConocoPhillips Company Benefits Committee P.O. Box 4783 Houston, TX 77210 (918) 661-5381 or (877) 812-7547

For convenience, the appeals procedures described on page N-31 are grouped by type of benefit:

- Health and welfare plan appeals (Medical, Vision, Dental, Flexible Spending Plan (HCFSA or DCFSA), EAP, Houston Onsite Medical Clinic, The Well Onsite Medical Clinic, Disability and Life (including AD&D) claims); and
- Severance Pay Plan appeals.

 “Severance Pay Plan Claims,” page N-39

Health and Welfare Plan Claims and Appeals

Information and Consents Required From You

When a claim or appeal is filed, you, your beneficiary and/or your covered dependents consent to:

- The release of any information the Claims Administrator or Appeals Administrator requests to parties who need the information for claims processing purposes; and
- The release of medical, vision or dental information (in a form that prevents individual identification) to ConocoPhillips for use in occupational health activities and financial analysis, as permitted by applicable law.

In considering a claim or appeal, the Claims Administrator or Appeals Administrator has the right to:

- Require examination of you and your covered dependents when and as often as required;
- Have an autopsy performed in the event of death, when permitted by state law; and
- Review a physician's or dentist's statement of treatment, study models, pre- and post-treatment X-rays and any additional evidence deemed necessary to make a decision.

In addition, for a claim or appeal for a disability benefit, you may be required to provide a signed authorization for the Claims Administrator or Appeals Administrator to obtain and release medical and financial information, and any other item the Claims Administrator or Appeals Administrator may reasonably require in support of your disability.

With respect to medical, vision, dental, EAP, Houston Onsite Medical Clinic, The Well Onsite Medical Clinic and FSP claims, before denying any claim or appeal, the Claims Administrator or Appeals Administrator will review covered and excluded benefits maintained by the Plan, to confirm that the denial is appropriate. If a service or supply is not expressly covered or excluded, the Administrator shall review its previous record of claims decisions for similar services and supplies that are not expressly covered or excluded by the Plan. Neither the Claims Administrator nor the Appeals Administrator can change the terms of the Plan by approving an excluded benefit or denying a specifically covered benefit.

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- ✓ In order to ensure your claims and appeals are decided with impartiality and to avoid any conflict of interest, the Company does not base personnel decisions for those individuals involved in the claims and appeals process on the outcomes of those claims and appeals. Insurers that are Claims Administrators or Appeals Administrators are not paid bonuses based on the number of denied appeals. Medical experts are chosen based on their professional qualifications and not on the claims and appeals outcomes.
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Timing Rules

The timeframe during which a decision on a claim or an appeal must be made begins when the claim or appeal is filed according to the established procedures, even if all the information necessary to make a decision is not included in the filing.

- For Life (including OAD) and AD&D claims, your claim is considered filed on the date you contact the Benefits Center and tell them you are making a claim.
- For all other claims, a written claim is not considered filed until it is received by the Claims Administrator or Appeals Administrator.

Required timeframes for you to file an initial claim are explained in the "How to File a Claim" section of each Plan's specific Summary Plan Description.

The deadline for a decision on certain claims and appeals can be extended if the Claims Administrator or Appeals Administrator determines that special circumstances require an extension of time for processing the claim. The Claims Administrator or Appeals Administrator will provide you with written notice of the extension prior to the termination of the original deadline.

All deadlines discussed in these claims and appeals procedures are based on calendar days, unless otherwise noted as business days. These deadlines can be extended by agreement between you and the Claims Administrator or Appeals Administrator.

Deadlines for Decisions on Benefit Claims

Medical, Vision, Dental, FSP, Employee Assistance Plan, Houston Onsite Medical Clinic Plan and The Well Onsite Medical Clinic Plan Claims

The Claims Administrator must notify you of its decision on your claim within the following timeframes:

For this type of claim:	Initial determination will be made:	Initial determination extension:
<u>Urgent Care Claims</u> ¹	As soon as possible after the claim is received, but not longer than 72 hours.	No extension is allowed; however, if you do not provide information necessary to make a decision on your claim, the <u>Claims Administrator</u> will notify you of the specific information needed within 24 hours after receiving the claim. You have a reasonable period of time (not less than 48 hours) to provide the information. The <u>Claims Administrator</u> will notify you of its decision as soon as possible, but not later than 48 hours after it receives the required information (or 48 hours after the deadline for you to provide the information, if earlier).
<u>Pre-Service Claims</u> ¹	Within a reasonable time after the claim is received, but not longer than 15 days.	May be extended for up to 15 days. If special circumstances beyond the control of the Plan exist, the <u>Claims Administrator</u> will notify you in writing before the initial determination deadline of why the extension is necessary, when a decision will be made and, if applicable, any additional required information. If an extension is necessary because you did not provide information necessary to make a decision, you have at least 45 days after you receive the notice to provide that additional information. The deadline for a decision will be extended by the length of time between the date you are notified that more information is needed and the date that the <u>Claims Administrator</u> received your response to the request for more information.
<u>Concurrent Care Claims</u> ¹	If you file an <u>urgent care claim</u> to extend an approved treatment plan, you will receive a decision within 24 hours after the request is received. ²	No extension if claim is considered urgent. If claim is not urgent, then use same provisions as above for <u>pre-service claims</u> .
	If the Plan shortens or withdraws approval of a treatment plan, you will be provided advance notice. ³	Extension does not apply.
<u>Post-Service Claims and Flexible Spending Plan Claims for Medical, Vision, Dental, Houston Onsite Medical Clinic, The Well Onsite Medical Clinic or Flexible Spending Plan</u>	Within a reasonable time after the claim is received, but not longer than 30 days.	(Same provisions as above for <u>pre-service claims</u>)

¹ Applies to Medical, Vision, Dental, EAP, Houston Onsite Medical Clinic or The Well Onsite Medical Clinic.

² This rule applies only if you request the extension at least 24 hours before the end of the previously approved course of treatment. If the request is not received within this timeframe, the request will be treated like any other new urgent care claim or pre-service claim.

³ The advance notice will be treated as a claim denial and will provide you sufficient time to appeal the Plan's decision to shorten or terminate treatment. Benefits will continue to be provided during the appeals process. You may also be eligible for an expedited external review (not applicable for EAP, Houston Onsite Medical Clinic and The Well Onsite Medical Clinic claims). See the "Expedited External Review" section for more information.

 "Expedited External Review," page N-39

If you try to make an urgent care claim or other pre-service claim and you do not make the claim as required by these claims procedures, the Claims Administrator will notify you as soon as possible, but not later than 24 hours after an urgent care claim is received, or 5 days after a pre-service claim is received, that you did not file the claim properly and tell you how you can file the claim properly. You may be notified orally; if so, you may request a written notice. You will only be notified if:

- You made the improper claim to someone at ConocoPhillips who customarily handles benefit matters, to the Claims Administrator, or to a case management or utilization review or similar company that provides services to the Plan; and
- Your improper claim included your name, the specific medical condition or symptom, and the specific proposed treatment, service or product that you are trying to get approved.

Disability, Life (including OAD) and AD&D Claims

In general, the Claims Administrator must notify you of its decision on your claim within the following timeframes:

For this type of claim:	Initial determination will be made:	Initial determination extension:
Short-Term Disability, Long-Term Disability and AD&D (<i>with disability claim</i>)	Within a reasonable time after the claim is received, but not longer than 45 days.	If circumstances beyond the control of the Plan exist, the <u>Claims Administrator</u> can extend the deadline for a decision up to 30 days. You will be notified in writing before the initial determination deadline of why the extension is necessary, when a decision will be made and, if applicable, any additional required information. If, before the end of the 30-day extension, the <u>Claims Administrator</u> determines (for reasons beyond the control of the Plan) that it cannot make a decision by the end of the initial extension period, the <u>Claims Administrator</u> may extend the deadline for up to 30 more days. If this happens, the <u>Claims Administrator</u> must give you a written notice of the second extension before the end of the first 30-day extension. Any notice of extension must specifically explain the standards that determine whether you are entitled to a benefit, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. If the extension is necessary because you did not provide all the information necessary to make a decision on your claim, the notice will specifically describe the required information and explain the standards that are used to decide whether you are <u>disabled</u> . You have at least 45 days after you receive the notice to provide that additional information. The deadline for a decision will be extended by the length of time between the date you are notified that more information is needed and the date that the <u>Claims Administrator</u> received your response to the request for more information.
Life, OAD, AD&D (<i>without disability claim</i>)	Within a reasonable time after the claim is received, but not longer than 90 days.	If special circumstances beyond the control of the Plan exist, the <u>Claims Administrator</u> can extend the deadline for a decision up to 90 days. You will be notified in writing before the initial determination deadline of why the extension is necessary and when a decision will be made. The extended deadline cannot be later than 180 days after the original claim was received.

Denials of Claims and Appeals

If any part of your claim or eligible appeal is denied, you will be given a written or electronic notice that will include:

- The specific reason(s) for the denial, including information to identify the claim involved with a description of the Plan's standard used for denying the claim, if applicable;
- References to each of the specific provision(s) of the Plan on which the denial is based;
- A description of any additional material or information you must provide in order for your claim to be approved, and an explanation of why that material or information is necessary;

✓ Written Approval Notices

In general, the Plan is not required to give you a written notice if a claim is approved. However, the Plan must give you a written or electronic notice by the deadlines indicated in this section if an urgent care claim or other pre-service claim is approved.



“Medical, Vision, Dental, FSP, Employee Assistance Plan, Houston Onsite Medical Clinic Plan and The Well Onsite Medical Clinic Plan Claims,” page N-32

✓ If your denied claim was a medical, vision, dental, EAP, Houston Onsite Medical Clinic or The Well Onsite Medical Clinic urgent care claim, the notice may be given to you orally first, followed by written or electronic notice within three days.

- A statement that you are entitled, upon request, to see all documents, records and other information relevant to your claim for benefits, and also that you are entitled to get free copies of that information;
- A statement describing any further appeal procedures and, if applicable, any voluntary external review offered by the Plan, including any applicable deadlines, and your right to obtain further information about such procedures; and
- A statement of your right to file a lawsuit in federal court under ERISA, including applicable contractual limitations period, if your claim is denied after completing the applicable claims and appeals process.

Additional Information Included for Medical, Vision, Dental, EAP, Houston Onsite Medical Clinic, The Well Onsite Medical Clinic or Disability Claims and Appeals

- The date of service, the health care provider, the claim amount, and the availability of the diagnosis and treatment codes with corresponding meanings of such codes (upon request);
- If any internal rule, guideline, protocol or standard was used in denying the claim, either that specific rule, guideline, protocol, or standard or alternatively a statement that such a rule, guideline, protocol or standard was used in denying the claim and that a copy will be provided to you free of charge upon request;
- If the claim denial was based on “medical necessity,” “experimental treatment” or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for applying the exclusion or limit as applied to your circumstances, or a statement that such an explanation will be provided to you free of charge upon request;
- If your denied claim was a medical, EAP, Houston Onsite Medical Clinic or The Well Onsite Medical Clinic claim, a statement disclosing the availability and contact information for any applicable office of health insurance consumer assistance or ombudsman;
- The availability of the claim denial in another language, as necessary;
- If your denied claim was a medical, vision, dental, EAP, Houston Onsite Medical Clinic or The Well Onsite Medical Clinic urgent care claim, a description of the expedited appeals procedure that applies to urgent care claims;
- If your denied claim was a disability claim, the following will also be provided:
 - (1) discussion of the decision, including explanation of the basis for disagreeing with or not following (a) the views presented by health care professionals treating the covered person and vocational professionals who evaluated the covered person; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denied claim, without regard to whether the advice was relied upon making the benefit determination; and (c) a disability determination made by the Social Security Administration; and (2) either the specific internal rules, guidelines, protocols, standards or other criteria relied upon in the making of the claim denial (including a copy of such document) or, alternatively, a statement that a specific internal rules guidelines, protocols, standards or other similar criteria of the plan do not exist; and
- Any additional requirements that may result from new regulations issued, including rights related to health care reform legislation.

Additional Information Included with Final Level of Appeal for Medical

- You will be provided additional information regarding the voluntary external review and a form for submitting a request for an external review, if applicable.

Appealing a Denied Claim

If any part of your claim is denied, you can appeal that denial. The goal of the appeals process is to ensure you have a full and fair review of your appeal. Pending the outcome of a medical, vision, dental, EAP, Houston Onsite Medical Clinic or The Well Onsite Medical Clinic concurrent care claim or urgent care claim appeal, your benefits for an ongoing course of treatment will not be reduced or terminated pending the outcome of the appeal. It is possible that you may also elect to have an expedited appeals process or an expedited external review (not applicable for EAP, Houston Onsite Medical Clinic or The Well Onsite Medical Clinic claims). Please see the “Expedited External Review” section for more information. Please see the “Claims Administrators and Appeals Administrators” section for the number of appeals available by types of claims.



“Claims Administrators and Appeals Administrators,” page N-28; “Expedited External Review,” page N-39

In your appeal, you may give the Appeals Administrator written comments, documents, records and other information relating to your claim that you want to have considered on appeal. You may also request to see and get free copies of all documents, records and other information relevant to your claim. You may also present evidence and written testimony in addition to written documentation not previously used in the initial claim decision.

Review of Denied Claim on Appeal

The appropriate Appeals Administrator will reconsider any denied claim that you appeal by the deadline. The appropriate Appeals Administrator must consider all information provided by you, even if this information was not submitted or considered in the original claim decision. For medical, vision, dental, FSP, EAP, Houston Onsite Medical Clinic, The Well Onsite Medical Clinic and disability appeals, the review will not defer to the original claim denial and will not be made by the person who made the original claim denial or a subordinate of that person.

Prior to issuing a denial of an appeal, the Appeals Administrator will provide you, free of charge, any new or additional evidence or rationale considered, relied upon or generated in connection with the claim. If you choose to respond or rebut this new evidence, you must do so prior to the deadline for the final determination. The deadline may be extended to provide you with a reasonable opportunity to respond. See page N-36 for specific detail regarding appeals timeframes.

If the claim denial is based on a medical judgment, the Appeals Administrator must get advice from a health care professional who has training and experience in the area of medicine. This professional cannot be a person who was consulted in connection with the original claim decision (or a subordinate of the person who was consulted in the original claim). Upon request, you will be provided with the names of any medical or vocational experts who were consulted in connection with your claim denial, even if the advice was not relied upon in making the denial.



“Deadlines for Decisions on Appeal,” page N-36



Your appeal to the appropriate Appeals Administrator must be made **in writing** within the following number of days from when you receive the denial of the claim:


- For the first level appeals, within 180 days for a medical, vision, dental, FSP, EAP, Houston Onsite Medical Clinic, The Well Onsite Medical Clinic, AD&D (with disability) or disability claim denial; and
- Within 60 days for a life (including OAD) or AD&D (without disability) claim denial.

To expedite your appeal, please indicate in large letters at the top of your letter that your letter is an appeal.

✓ **Special Rule for Urgent Care Appeals** (*Applicable to Medical, Vision, Dental, EAP, Houston Onsite Medical Clinic and The Well Onsite Medical Clinic only*)

For urgent care claim appeals, there is only one level of review on appeal, with the exception of prescription drug urgent care claim appeals. Urgent care claim appeals aren't required to be in writing; you can make urgent care claim appeals orally. In addition, all communications between you and the Plan for an urgent care claim appeal may be conducted by telephone, facsimile or other available expedited method of communication.

For medical urgent care claim appeals, you can request an expedited external review to run concurrently with the appeals process. For more information regarding expedited external review, see page N-39.

 "Expedited External Review," page N-39

✓ If your denied appeal was a medical, vision, dental, EAP, Houston Onsite Medical Clinic or The Well Onsite Medical Clinic urgent care claim appeal, the notice may be given to you orally first, followed by written or electronic notice within three days.

Deadlines for Decisions on Appeal

The appropriate Appeals Administrator must make its decision on your appeal within the following timeframes:

For this type of appeal:	The timeframe for a final determination is:	Final determination extension:
Urgent Care Appeal ¹	As soon as possible after the appeal is received, but not longer than 72 hours	No extension allowed
Pre-Service Appeal ¹	Within a reasonable time after the appeal is received, but not longer than 15 days	No extension allowed
Concurrent Care Appeal ¹	If this is an appeal to extend a course of treatment, it will be treated as an urgent care or pre-service appeal as applicable	No extension allowed
	If this is an appeal related to reduction or termination of a preapproved benefit, a decision must be provided before reduction or termination of benefit occurs	No extension allowed
Post-Service Appeal ¹ (<i>including eligibility</i>) (<i>not applicable to the EAP</i>)	Within a reasonable time after the appeal is received, but not longer than 30 days	No extension allowed
Short-Term and Long-Term Disability and AD&D (<i>with disability</i>)	Within a reasonable time after the appeal is received, but not longer than 45 days	Extension is not to exceed 45 days from the initial 45-day initial determination deadline
Life, AD&D (<i>without disability</i>)	Within a reasonable time after the appeal is received, but not longer than 60 days	Extension is not to exceed 60 days from the initial 60-day initial determination deadline

¹ Applies to Medical, Vision, Dental, FSP, Houston Onsite Medical Clinic or The Well Onsite Medical Clinic.

For life (including OAD), AD&D and disability appeals, if an extension is necessary because you did not provide all the information necessary to make a decision on your appeal, you will receive a notice specifically describing the required information, and you will have a reasonable period of time after you receive the notice to provide that information. The deadline for making the decision on the appeal will be extended by the length of time that passes between the date you are notified that more information is needed and the date that the Appeals Administrator receives your response to the request for more information.

Denials of Appeals

If any part of your claim is denied on appeal, you will be given a written or electronic notice with the information listed on page N-34.

Second Level Appeal to Appeals Administrator

If the first level Appeals Administrator denies your medical, vision, dental, FSP, EAP, Houston Onsite Medical Clinic or The Well Onsite Medical Clinic claim on appeal, you can make a second, and final, appeal to the second level Appeals Administrator.

 *“Claims Administrators and Appeals Administrators,” page N-28*

All the rules for the first level appeal will apply to your final appeal, except for the following changes in deadlines:

- You will have a reasonable period of time (designated by the Plan as 90 days) to make your final appeal after you receive the first appeal denial.
- All appeal deadlines that were measured from the date of your first appeal, will now be measured from the date your second appeal is filed with the Appeals Administrator.

 *“Appealing a Denied Claim,” page N-35*

In a final appeal, the health care professional consulted by the second level Appeals Administrator cannot be a person who was consulted by the Claims Administrator or by the Appeals Administrator in connection with the original claim denial or the first appeal denial (or a subordinate of the person who was consulted).

Authority of the Appeals Administrator to Make Final Binding Decisions on Appeals

The Appeals Administrator that makes the final appeals decision acts as fiduciary under ERISA and has the full discretion and authority to:

- Make final determinations of all questions relating to eligibility for any Plan benefit and to interpret the Plan for that purpose; and
- Make final and binding grants or denials of benefits under the Plan.

Benefits under the Plan only will be paid if the appropriate Appeals Administrator decides in its sole discretion that the applicant is entitled to them. The determination of the appropriate Appeals Administrator on appeal will be final and binding.

✓ This section regarding Second Level Appeals does not apply to urgent care claims (with the exception of prescription drug urgent care claim appeals), claims relating to eligibility to participate in a Plan, or claims on STD, LTD, Life, OAD or AD&D Plans.

External Reviews

(Applies to Medical Claims Only)

Availability of External Review

If, after exhausting the two levels of appeal¹, you are not satisfied with the final determination and your claim involves medical judgment, as determined by the independent review organization (IRO), rescission of coverage, surprise billing, your ability to meet a standard for an incentive payroll credit under the U.S. Health Improvement Program by different means, treatments considered investigational and/or experimental or mental health/substance use disorder conditions, you may choose to participate in the voluntary external review process. See the chart on the next page for the procedures and timeline and the “Expedited External Review” section, if applicable.

 “Expedited External Review,” page N-39

External Review Process & Timeline

Step in External Review Process	Timeframe
Request for <u>external review</u> after exhausting appeals process ¹ must be made within:	123 days from receipt of benefits denial notice
The Benefits Committee will conduct a preliminary review ² of your request in:	Five business days following receipt of <u>external review</u> request
The Benefits Committee must notify you in writing of the preliminary review decision with reasons for the approval or denial ³ of the preliminary review decision within:	One business day after completion of preliminary review
If preliminary review is approved, the Benefits Committee will assign your appeal to an <u>IRO</u> and must provide all information that was used in determining your denied appeal to the <u>IRO</u> within:	Five business days of assignment of <u>IRO</u> . If this is not done, the <u>IRO</u> may stop its review and reverse the Benefits Committee's decision. The <u>IRO</u> will notify you and the Benefits Committee of this action within one business day of the reversal decision
Once assigned, the <u>IRO</u> will notify you that your <u>external review</u> request has been accepted for review and you can provide additional information to the <u>IRO</u> within:	Ten business days following receipt of notice from <u>IRO</u>
The <u>IRO</u> must forward any additional information submitted by you to the Benefits Committee within:	One business day of receipt
If, based on the additional information, the Benefits Committee reverses its denial and provides coverage, notice must be sent to you and the <u>IRO</u> within:	One business day of decision
If the Benefits Committee does not reverse its denial, the <u>IRO</u> must notify ⁴ you and the Benefits Committee of its decision within:	45 days after initial receipt of request for review from the Benefits Committee
The <u>IRO's</u> decision is the final decision. If the decision reverses the Plan's decision, the Plan must provide coverage or payment for the claim:	Immediately provide coverage or authorize payment

¹ For an urgent care claim or concurrent care claim or if the Plan has not followed Department of Labor proscribed guidelines, you may request an external review prior to completion of the full appeals process.

² Review includes whether 1) you are eligible for external review; 2) denied claim or appeal does not relate to Plan eligibility; 3) you or your eligible dependent are covered under the health plan, were provided all information required to process the claim, and you have completed all internal Plan appeal processes.

³ Reason for a denial will include if and why your request was incomplete and a deadline for supplying the information to make the request complete if necessary.

⁴ The notice will include 1) reason for the external review request, including information sufficient to identify the claim (date(s) of service, provider, claim amount (if applicable), diagnosis and treatment codes (with their meanings) and the reason for the prior denial); 2) date the IRO received the review assignment and date of its decision; 3) references to evidence and documentation used for decision, including specific coverage provisions and evidence-based standards; 4) principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards relied on; 5) statement that the IRO's determination is binding unless other remedies are available to you (or the Plan) under state or federal law; 6) statement disclosing the availability and contact information for any applicable office of health insurance consumer assistance or ombudsman; and 7) any additional requirements as required by health care reform legislation.

Expedited External Review

You can request an expedited external review if:

- Your claim denial involves a medical condition that would cause serious jeopardy to your life or health or your ability to regain maximum function if you were forced to abide by the timeframe of the appeals process; or
- Your claim denial involves an admission, availability of care, continued stay or health care item or service related to emergency care and you have not been discharged from the medical facility.

The preliminary review will take place immediately upon receiving the external review request. The Benefits Committee will send you a notice whether your request is approved or denied.

Once your request is accepted, the Benefits Committee will send all necessary documents and information considered in making the benefits denial to the assigned IRO. The documents and information will be provided electronically, by telephone, fax or any other expeditious method available.

The IRO will consider the documents and information received to the extent the information or documents are available and the IRO considers them appropriate. The IRO will provide notice of its final external review decision as expeditiously as your medical condition or circumstances require but not more than 72 hours after the IRO receives the expedited external review request. If the final external review decision is not in writing (you received a verbal decision), the IRO must provide written confirmation of the decision to you and the Benefits Committee within 48 hours after the verbal decision was provided to you.

Fraudulent Claims

If the Plan finds that you or someone on your behalf have submitted a fraudulent claim or intentional misrepresentation of material facts to the Plan, the Plan has the right to recover the payments of any fraudulent claim(s) and/or expenses paid by the Plan and may take legal action against you. Upon determining that a fraudulent claim has been submitted, the Plan has the right to permanently terminate the coverage provided for you and your dependents under the Plan, and the Benefits Committee has the authority to take any actions it deems appropriate to remedy such violations, including pursuing legal action or equitable remedies to recoup any payments made by the Plan to any party, regardless of when such fraudulent claim was discovered. Such action will not preclude the Company from taking other appropriate action. If medical, vision, dental, EAP, Houston Onsite Medical Clinic or The Well Onsite Medical Clinic coverage is terminated retroactively, the Plan will give the participant a written 30-calendar-day notice prior to rescission. You will have the right to appeal the decision by going through the appeals process that applies to the specific benefit being rescinded.

Severance Pay Plan Claims

Filing a Claim

You may file a claim if you believe you are entitled to benefits under the Severance Pay Plan but do not receive them. The claim must be presented in writing to the Benefits Committee within 24 months after your last date of employment with the Company.

 "Contacts," page A-1


If your claim is denied in whole or in part by the Benefits Committee, you will receive a written notice of the denial within a reasonable period of time, but not later than 90 days after receipt of the claim by the Benefits Committee. If special circumstances require an extension of time for processing, a decision will be made within a reasonable period of time, but in no case later than 180 days after receipt of your claim.

If any part of your claim is denied, you will be given written notice that will include:

- The specific reason(s) for the denial;
- References to each of the specific provision(s) of the Plan on which the denial is based;
- A description of any additional material or information you must provide in order for your claim to be approved, and an explanation of why that material or information is necessary;
- An explanation of the appeals procedures, including time limits that apply; and
- A statement of your right to file a lawsuit in federal court under ERISA, if your claim is denied on appeal.

Review of Claim Denial

If any part of your claim is denied, you can appeal that denial by filing a written request for review with the Benefits Committee (the Committee) within 60 days after the date you received written notice of denial. You have the right to review free of charge all pertinent documents, records and other information of the Plan that relate to your claim and to submit issues and comments in writing. A document, record or information is relevant if it was relied on in a determination of your benefits or if it was submitted, considered or generated in connection with making a determination of your benefits.

 *"Claims Administrators and Appeals Administrators,"
page N-28*

The Committee will review your appeal, make a decision and notify you regarding the claim within 60 days after you filed the request for review. If special circumstances require an extension of time for processing, a decision will be made within a reasonable period of time, but in no case later than 120 days after receipt of your request for review. If the extension of time is due to your failure to provide information necessary to decide your claim, the period of time for deciding the appeal will be suspended until you respond to the request for additional information.

If any part of your claim is denied on appeal, you will be given written notice that will include:

- The specific reason(s) for the denial;
- References to each of the specific provision(s) of the Plan on which the denial is based;
- A statement that you are entitled, upon request, to see all documents, records and other information relevant to your claim for benefits, and to get free copies of that information; and
- A statement of your right to file a lawsuit in federal court under ERISA.

You must properly file a claim for benefits and then request a review of any complete or partial claim denial before you seek a review of your claim for benefits in a court of law. A decision on a review of a claim denial shall be the final decision of the Committee. After this decision, you may seek judicial remedies in accordance with your rights under ERISA.

ERISA Plan Information

The component plans listed below are governed by ERISA — and are subject to its provisions. All the component plans listed below, along with certain other ConocoPhillips employee benefit plans described in separate summary plan descriptions, are considered a single plan for annual Form 5500 filing purposes. For all other purposes under ERISA, the Internal Revenue Code of 1986, as amended (“Code”), COBRA, HIPAA, the Affordable Care Act and other legal purposes, each component plan (or particular program offered under each plan), is a separate plan.

The plan number for the Wrap Plan is 502.

The plan year for the Wrap Plan begins on January 1 and ends on December 31 each year.

ConocoPhillips Medical and Dental Assistance Plan

(Commonly referred to as the Employee Medical Plan, the Employee Vision Plan, the Employee Dental Plan, the Houston Onsite Medical Clinic Plan and The Well Onsite Medical Clinic Plan)

Type of Benefit	Group health benefits
Plan Funding/Sources of Contributions	<p>The medical options and the dental coverage under the Plan are self-insured by ConocoPhillips Company. Any employee contributions are separately accounted for from ConocoPhillips Company’s general assets. All expenses and charges are paid from Plan assets, unless paid by ConocoPhillips Company or participating employers.</p> <p>The vision coverage options and Cigna Global Health Benefits are funded pursuant to an insurance contract.</p> <p>The Company pays reasonable expenses necessary for the operation of the Houston Onsite Medical Clinic and The Well Onsite Medical Clinic. Participants are not required to make contributions to have access to medical services at fixed rates and the Plans are not insured.</p>
Plan Medical Director	General Manager, Health Services & CMO

ConocoPhillips Flexible Spending Plan

(Commonly referred to as the Flexible Spending Plan or FSP)

Type of Benefit	<p>Cafeteria plan under Section 125 of the Internal Revenue Code. The FSP-HCFSA is intended to qualify as a self-insured medical reimbursement plan under Code Section 105(h), and the medical care expenses reimbursed under the FSP-HCFSA are intended to be eligible for exclusion from the participating employee’s gross income under Internal Revenue Code section 105(b). The FSP-HCFSA is the only benefit under the FSP that is subject to <u>ERISA</u>.</p> <p>The Dependent Care Flexible Spending Account (FSP-DCFSA) is intended to qualify as a dependent care assistance plan under Code section 129, and the dependent care expenses reimbursed under the FSP-DCFSA are intended to be eligible for exclusion from the participating employee’s gross income under Internal Revenue Code section 129(a).</p> <p>The FSP-HCFSA is the only benefit under the FSP subject to <u>ERISA</u>. Information about the FSP and the FSP-DCFSA is included for convenience of reference only.</p>
Plan Funding/Sources of Contributions	<p>The Company accounts for employee monthly contributions to the FSP-HCFSA and FSP-DCFSA and uses the bookkeeping accounts to reimburse eligible expenses. The Company pays the expenses of administering the FSP-HCFSA and FSP-DCFSA (offset by any employee contributions that are forfeited under the “use or lose” rule and by any uncashed benefit checks). Any remaining funds after claims and administrative expenses have been paid will be distributed to current Plan participants on a per capita basis no later than the third year following the Plan year.</p>

ConocoPhillips Disability Plan (Includes Short-Term Disability and Long-Term Disability coverage)
(Commonly referred to as the STD Plan and the LTD Plan)

Type of Benefit	Disability benefits
Plan Funding/Sources of Contributions	STD Plan disability benefits are funded through the general assets of the Company at no cost to eligible employees. LTD Plan disability benefits are funded through an insurance contract. The cost of LTD Plan benefits are paid entirely by participating employees. Heritage Burlington Resources Inc. employees disabled prior to Jan. 1, 2009 have long-term disability benefits funded either through the general assets of the Company or through various insurance contracts, depending on when the employee was disabled.

ConocoPhillips Group Life Plan (Includes Accidental Death and Dismemberment)
(Commonly referred to as the Employee Life Plan and the Employee AD&D Plan)

Type of Benefit	Life and accidental death and dismemberment benefits
Plan Funding/Sources of Contributions	Benefits are funded through insurance contracts, excluding occupational accidental death benefits. The costs of basic life are paid entirely by the Company, with no cost to employees. The costs of supplemental life, dependent life and accidental death and dismemberment benefits are paid entirely by participating employees. Occupational accidental death benefits are funded through the general assets of the Company at no cost to eligible employees. The benefit is taxable income, not grossed up for taxes and not subject to interest for the time between death and payment dates.

ConocoPhillips Employee Assistance Plan
(Commonly referred to as the Employee Assistance Plan or EAP)

Type of Benefit	Employee assistance
Plan Funding/Sources of Contributions	Benefits under the EAP are provided at no cost to employees. Benefits provided by TELUS Health are funded through an insurance contract.
Plan Medical Director	General Manager, Health Services & CMO

ConocoPhillips Severance Pay Plan
(Commonly referred to as the Severance Pay Plan)

Type of Plan	Severance
Plan Funding/Sources of Contributions	The Company pays reasonable expenses necessary for the operation of the Severance Pay Plan and payment of benefits from the general assets of the Company. Neither employees nor participants are required or are permitted to make contributions to the Severance Pay Plan. The Severance Pay Plan is not insured.

Glossary



65-point rule: The 65-point rule is used to determine both eligibility for retiree benefits and any available cost sharing level. Points are determined on your termination date, regardless of the reason for termination. **Note:** This method is different from the points calculation method used by the pension plan. To be eligible, you must be at least age 55 and have a minimum of 10 completed years of service on your termination date.

("Completed years of service" is the difference between your termination date and your company service date.) Points to determine any available cost sharing level for your retiree medical coverage, if eligible, will be determined by adding your age to your completed years of service as of Dec. 31 of the calendar year of your termination date. **Note:** Effective Jan. 1, 2013, the age requirement of the 65-point rule changed from 50 to 55. Employees who were eligible as of Dec. 31, 2012 under the prior rule, persons enrolled in retiree medical, dental or life benefits on Dec. 31, 2012 or persons who were not enrolled in a retiree benefit on Dec. 31, 2012 but were eligible on their termination date, will continue to be eligible for these retiree benefits under applicable eligibility requirements as of Dec. 31, 2012.

✓ Please note that some of the terms defined in this Glossary have more than one definition, depending on the specific benefit plan. Those terms are indicated by an asterisk.

accidental injury: Trauma or damage to a part of the body that occurs as the result of a sudden, unforeseen external event that occurs by chance and/or from unknown causes and that's not contributed to by disease, sickness or bodily infirmity. An accidental injury doesn't include:

- Injury incurred while in active, full-time military; and
- Injury incurred while committing a felony or other serious crime or assault.

active employee: An employee who's on the direct U.S. dollar payroll.

actively at work* (for the life and AD&D options under the Group Life Plan):

Performing all of the usual and customary duties of your job at a place required by the employer in your usual number of hours. Includes weekends, Paid Time Off, holidays, business trips or business closures, provided you were actively at work on the last scheduled work day preceding such time.

actively at work* (for the LTD Plan): Performing all of the usual and customary duties of your job at a place required by the employer. Includes weekends, Paid Time Off, holidays, leaves of absence (excluding leave of absence-Labor Dispute) not due to disability as defined for LTD benefits eligibility, and business closures.

affiliate: A member of the affiliated group.

*** This term has multiple definitions.**

affiliated group: Consists of ConocoPhillips and entities of which ConocoPhillips has at least a 5% ownership interest.


affiliate providers: A network of licensed clinical counselors who contract with the Employee Assistance Plan's Claims Administrator to provide assessment, referral and brief counseling services (30 to 50 minutes per session). These individuals must possess at least a Master's level degree and may include licensed social workers, professional counselors, marriage and family therapists or psychologists.

air bag: An inflatable supplemental passive restraint system installed by the manufacturer of the motor vehicle or its proper replacement parts installed as required by the motor vehicle's manufacturer's specifications that inflates upon collision to protect an individual from injury and death. An air bag is not considered a seat belt.

annual deductible: The amount you pay each calendar year before the Plan typically pays benefits. (Some benefits may be covered, subject to law and the Plan, before you reach your annual deductible.) For the medical options and dental coverage, there are two types of deductibles — the annual individual deductible and the annual family deductible. The Plan defines amounts that apply to the annual deductible.

 *"Some Basic Terms – Annual Deductible," page B-23*


annual out-of-pocket maximum: The maximum amount you pay each calendar year for covered services, as defined by the Plan which generally includes the annual deductible and coinsurance. Once you reach your out-of-pocket maximum, the Plan pays 100% for most covered services.

 *"Some Basic Terms – Annual Out-of-Pocket Maximum," page B-24*

annual pay: Pay means base salary and regularly scheduled overtime hours. For certain work schedules, annual pay may be calculated based on average annual working hours. Annual pay excludes:

- Overtime resulting from the 19/30 work schedule;
- Unscheduled overtime, upgrade pay, holiday pay, allowances, shift differential and callout pay;
- Awards, commissions and bonuses;
- Grant, award, sale, conversion and/or exercise of shares of stock or stock options, including, but not limited to, the grant, award, transfer, exercise and/or lapse of restrictions of qualified or nonqualified stock options, restricted stock, restricted stock units, phantom stock, stock appreciation rights, performance share units or any other form of equity-type compensation;
- Contributions made by the Company on your behalf to any deferred compensation arrangement or pension plan; and
- Any other compensation.

Appeals Administrator: An entity that processes appeals regarding benefit claims.

 *"Claims Administrators and Appeals Administrators," page N-28*

assessment: The process of identifying the client's problem, evaluating his or her strengths and needs and selecting relevant intervention or resources to address the problem.

beneficiary, beneficiary(ies): The person(s) or entity(ies) you designate to receive specific benefits in the event of your death.

Blue Distinction Centers (BDC): Blue Distinction® is a designation given by BCBSTX companies to health care facilities (typically hospitals) that have demonstrated expertise in delivering quality health care. At the core of the program are Blue Distinction Centers (BDC) and Blue Distinction Centers Plus (BDC+) for Specialty Care. BDC facilities are recognized for providing distinguished care while BDC+ facilities are recognized for their expertise in delivering quality and cost-efficient specialty care. The goal of Blue Distinction is to help consumers find consistent specialty care while enabling and encouraging health care professionals to improve the overall quality and cost of care nationwide.

brand-name drug: A prescription drug that's protected by a trademark registration. Brand-name drugs include **preferred brand drugs** and **non-preferred brand drugs**.

- **Preferred brand drugs (also known as preferred drugs)** are included on the prescription drug Claims Administrator's list of carefully selected brand-name medications that can assist in maintaining quality care for patients, while lowering the Plan's cost for prescription drug benefits. The prescription drug Claims Administrator enlists an independent Pharmacy and Therapeutics Committee to review each drug on the list for safety and effectiveness.
- **Non-preferred brand drugs** are brand-name drugs that aren't on the prescription drug Claims Administrator's list of preferred drugs.

Change of Control: The meaning described in Appendix A to the Severance Pay Plan.

 *"Appendix A — Change of Control Provisions," page M-11*

Claims Administrator: The entity responsible for processing benefit claims and for any other functions as explained in this handbook.

 *"Contacts," page A-1*

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that provides for continuation coverage for employees and covered dependents who, under certain circumstances, would otherwise lose their group health coverage.

coinsurance: The percentage of a covered expense that you're responsible for paying.

common carrier: A conveyance operated by a concern, other than the Company, organized and licensed for the transportation of passengers for hire and operated by that concern. Common carrier will not mean any such conveyance which is hired or used for a sport, gamesmanship, contest, sightseeing, observatory and/or recreational activity, regardless of whether such conveyance is licensed.

company service date: This date is used to determine an employee's eligibility for certain plans and programs. Unless adjusted by the Service Recognition Policy, the company service date is the employee's original hire date.

comparable employment level: A new job has a comparable employment level to a current job if it is no lower than one level below the level of the current job. For this purpose, "level" means salary grade level established by the Company.

comparable pay: A new job has comparable pay to a current job if weekly base wages or base salary for the new job — including any pay for regularly scheduled overtime, but excluding overtime due to the 19/30 work schedule — are equal to or greater than 80% of the weekly pay for the current job.

concurrent care claim: An approved ongoing course of treatment to be provided over a period of time or for a specified number of treatments.

consultation and X-rays (by a dentist): Dental services requested by a physician to rule out possible dental problems as a cause of a patient's medical condition.

Consumer Price Index (CPI): The Consumer Price Index used for the Long-Term Disability Plan is the CPI-W, the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor. If the CPI-W is discontinued or changed, the insurer reserves the right to use a comparable index.

copay (also known as a copayment): The fixed amount of a covered expense that you're responsible for paying.

corporate event: Any of the following events:

- The sale of an asset or assets by the Company or by a member of the employer to one or more unrelated entities;
- The sale of stock of an entity that is owned by the Company or by a member of the employer to one or more unrelated entities;
- The formation of a joint venture between the Company or a member of the employer and one or more unrelated entities;
- The sale of an interest in a joint venture by the Company or a member of the employer to one or more unrelated entities;
- The cessation of the Company's role as operator of a joint venture or business, and the commencement of that role by one or more unrelated entities; or
- The transfer of a job, function or service formerly performed by employees of the Company or a member of the employer to one or more unrelated entities.

covered accident: An event not otherwise excluded by the insurance contract that results in a bodily injury or death for which the Claims Administrator determines AD&D benefits are payable.

covered expenses: Reasonable and customary charges for medically necessary services and supplies that are:

- Recommended by the attending physician;
- Required in connection with the treatment of accidental bodily injury, disease or pregnancy, or in connection with the care and treatment of a newborn dependent child prior to release from a hospital; and
- As defined by the medical plan.

covered trip: For travel assistance benefits under the Basic Life option of the Group Life Plan, a covered person is considered to be on a covered trip when he or she is traveling more than 100 miles from his or her principal residence (national or international travel) for 90 days or less, the travel is covered under the Plan, and the travel is not excluded under Plan provisions.

 "Travel Assistance Coverage Exclusions and Limitations," page I-13

creditable prescription drug coverage: Prescription drug coverage that is, on average, at least as good as the Medicare standard prescription drug coverage. This determination of creditable coverage is defined by the Centers for Medicare and Medicaid Services (CMS) and is made by independent actuarial attestation.

current monthly earnings (for the LTD Plan): Monthly earnings you receive from the Company or other employment while disabled.

custodial care: Any service primarily for personal comfort for convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial care services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g., simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g., bathing, eating, dressing, etc.).

date of layoff: The last day a participant who is laid off is an employee as reflected by the termination date recorded in the Company's personnel records.

disabled* (for the Employee Medical Plan, the Employee Vision Plan, the Employee Dental Plan, the EAP, the Houston Onsite Medical Clinic Plan and The Well Onsite Medical Clinic Plan): Any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. As a condition to the continued coverage of a child as a disabled dependent beyond age 26, the Claims Administrator may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two-year period following the child reaching age 26 or initial eligibility after age 26.

disabled* (for COBRA qualified beneficiaries): You qualify for Social Security disability benefits during the first 60 days of COBRA coverage.

disabled, disability* (for the Flexible Spending Plan's Dependent Care Flexible Spending Account): A spouse who is physically or mentally incapable of self-care and has the same principal place of abode as you for more than 50% of the current calendar year.

disabled* (for the dependent life and AD&D options under the Group Life Plan): Incapable of self-sustaining employment because of a mental or physical handicap. In addition, includes a diagnosis of a life expectancy of 24 months or less.

* **This term has multiple definitions.**

disabled, disability* (for the STD Plan): A nonoccupational illness or injury (as defined by the Plan) that prevents an eligible employee from performing, for a temporary period of time, the regular duties of his or her job with the Company or other normal activities.

disabled, disability* (for the LTD Plan): Means that due to sickness, pregnancy, mental illness, substance abuse or an accidental bodily injury, you are receiving appropriate care and treatment from a physician on a continuing basis and:

- During your elimination period and the next 24-month period, you're unable to perform the essential duties of your own occupation with the Company and are unable to earn more than 80% of your pre-disability earnings or indexed pre-disability earnings. (**Note:** If at the end of the elimination period, you are still prevented from performing one or more of the essential duties of your own occupation, but your current monthly earnings are equal to or greater than 80% of your pre-disability earnings, your elimination period will be extended for a total period of 12 months from the original date of disability, or until such time as your current monthly earnings are less than 80% of your pre-disability earnings, whichever occurs first); or
- After the 24-month period, you're unable to earn more than your elected LTD benefit coverage level (50% or 60% of your indexed pre-disability earnings) from any employer at any gainful occupation for which you are reasonably qualified, taking into account your training, education, experience and pre-disability earnings.

Your loss of earnings must be a direct result of your sickness, pregnancy, mental illness, substance abuse or accidental bodily injury. The Claims Administrator has the sole authority for determining disability. Economic factors, such as, but not limited to, recession, job obsolescence, pay cuts and job-sharing will not be considered in determining whether you meet the loss of earnings test. Benefits due to mental illness and substance abuse are limited. See details in the LTD Plan.

 "Maximum LTD Benefit Duration," page L-13

If your job requires a license, "loss of license" for any reason doesn't constitute disability.

domestic partner: A person of the same or opposite sex who has demonstrated a commitment to a long-term relationship with you. You and your domestic partner must meet **all** of the following requirements:











- You intend to remain each other's sole domestic partner indefinitely;
- You are both at least 18 years old (or of legal age);
- You are both mentally competent to enter into contracts;
- You are not related by blood;
- You haven't been married to each other;
- You and your domestic partner are not married to anyone else;
- You have the same principal place of abode for the tax year;
- Your domestic partner is a member of your household for the tax year and intends to remain so indefinitely;
- You have provided more than 50% of your domestic partner's total support for the tax year;
- The relationship does not violate local law; and
- You lived together for six months before enrolling your domestic partner, are jointly responsible for each other's welfare and are financially interdependent.

EAP providers:

- Must meet the criteria to be master's level counselor and have a minimum of three years' experience providing EAP services;
- Are not qualified to prescribe or dispense medications; and
- Specialize in workplace issues and performance problems, organizational stresses, substance use disorder assessment and issues, and short term counseling for life concerns.

*** This term has multiple definitions.**

eligible dependent (for the Employee Medical Plan, the Employee Vision Plan, the Employee Dental Plan, the EAP, the Houston Onsite Medical Clinic Plan, The Well Onsite Medical Clinic Plan, Flexible Spending Plan and dependent life and AD&D coverage under the Group Life Plan):

For the Plans shown below:	The applicable definition is shown in each chapter's "Dependent Eligibility" section:
Employee Medical Plan	 "Dependent Eligibility," page B-6
Houston Onsite Medical Clinic Plan	 "Dependent Eligibility," page C-3
The Well Onsite Medical Clinic Plan	 "Dependent Eligibility," page D-3
Employee Vision Plan	 "Dependent Eligibility," page E-4
Employee Dental Plan	 "Dependent Eligibility," page F-4
EAP	 "Dependent Eligibility," page H-4
Flexible Spending Plan — Health Care Flexible Spending Account	 "Eligible Dependents Under the HCFSA", page G-11
Flexible Spending Plan — Dependent Care Flexible Spending Account	 "Eligible Dependents Under the DCFSA", page G-14
Dependent life under the Group Life Plan	 "Dependent Eligibility," page I-4
Dependent AD&D under the Group Life Plan	 "Dependent Eligibility," page J-4

emergency care: Health care services provided in a hospital or other state licensed emergency facility (emergency room) or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment of bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. Serious disfigurement; or
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

employee: For the Severance Pay Plan, a person who is on the Company's direct U.S. dollar payroll, for whom the Company or its agent issues a form W-2 to report compensation to the Internal Revenue Service, and who is in a regular full-time or regular part-time employment status on the date of layoff.

The term "employee" shall not include:

- A temporary employee, intermittent employee, an individual who is designated, compensated or otherwise classified or treated as an independent contractor, contingent worker, or contract worker, whether or not he is later classified or determined at any time to be a common law employee, "leased employees" within the meaning of Internal Revenue Code Section 414(n), commission agent and other non-regular employees of the Company; or
- A person who is retroactively reclassified as a common law employee by the Internal Revenue Service or by a court. Notwithstanding any other provision of the Plan, any person not on a direct U.S. dollar payroll, including, without limitation, an individual employed by (or whose services are provided through) a temporary help firm, technical help firm, staffing firm, employee leasing firm, professional employer organization or other staffing firm, whether or not deemed to be a common law employee, is not eligible to participate in the Plan.

employer: For the Severance Pay Plan, ConocoPhillips and the members of its controlled group of corporations as that term is defined in section 414(b) of the Internal Revenue Code (IRC) of 1986, as amended, and entities under common control with ConocoPhillips as defined in section 414(c) of the Internal Revenue Code (IRC) of 1986, as amended.

entitled to Medicare: An individual who:

- Is receiving Medicare benefits; or
- Would receive such benefits if he or she made application to the Social Security Administration.

EOI: See evidence of insurability.

ERISA: Employee Retirement Income Security Act of 1974, as amended from time to time.

essential duties (for the LTD Plan): Duties that are substantial, not incidental, and fundamental or inherent to the performance of your own occupation and cannot be reasonably omitted or modified. Your ability to work the number of hours in your regularly scheduled workweek is an essential duty.

evidence of insurability (EOI), evidence of good health: A statement providing your medical history. The Claims Administrator will use this statement to determine your insurability under the applicable Plan.

external review: A review of a denied claim or appeal by an Independent Review Organization (IRO).

family medical leave of absence (FMLA or FML): Leave taken under the terms of the Family and Medical Leave Act of 1993 (as amended). Includes taking the leave all at once, or, when medically necessary, can be intermittent FMLA in separate blocks of time or by reducing the time of each work day or workweek.

fertility: Condition that may require treatment if there is an inability to conceive a child after one year of unprotected sexual intercourse, or the inability to attain or maintain a viable pregnancy or sustain a successful pregnancy.

foreign adoption (outside the United States) (for the Employee Medical Plan, the Employee Vision Plan, the Employee Dental Plan, the EAP, the Houston Onsite Medical Clinic Plan and The Well Onsite Medical Clinic Plan): A foreign-born child adopted by a (i) covered employee and/or his or her eligible spouse or (ii) covered employee's domestic partner, as applicable, in a foreign country (outside the United States) is considered to be an adopted son or daughter if under the age of 18 (or in the case of an orphan, under the age of 16) and meets one of the following:

- The foreign-born child has an Immediate Relative-2 (IR-2) Visa, IR-3 Visa or IR-4 Visa and enters the United States under a decree of simple adoption, and the competent authority enters a decree of adoption; or
- The foreign-born child has an IR-2 Visa, IR-3 Visa or IR-4 Visa and enters the United States under a decree of simple adoption, and the state court in your home state enters a decree of re-adoption or the state court in your home state otherwise recognizes the adoption decree of the foreign-sending country; or

- The foreign-born child has an IR-4 Visa and enters the United States under a guardianship or legal custody arrangement and the state court of your home state enters a decree of final adoption.

full-time student: An eligible child (or eligible spouse, for the Flexible Spending Plan's Dependent Care Flexible Spending Account) as defined under the applicable Plan who's enrolled for the number of hours or courses the school considers to be full-time attendance during each of five calendar months during the calendar year in which the taxable year of the covered employee begins. A child (or spouse under the Flexible Spending Plan's Dependent Care Flexible Spending Account) who's attending school only at night isn't considered to be a full-time student. However, full-time attendance at school can include some attendance at night as part of a full-time course of study.

General Release of Liability (Release): A waiver and Release signed by the participant, or, if the participant is deceased, signed by the participant's spouse or the representative of the participant's estate, in a form acceptable to the Company, of all claims, whether or not asserted, arising out of or related to the participant's employment or termination from employment. Such waiver and Release shall apply to claims against the Company or other members of the affiliated group by participants, including — without limitation — any claims of discrimination arising out of or incident to a participant's employment and termination thereof, other than claims made for work-related injuries under applicable Workers' Compensation statutes, claims for benefits payable in accordance with the terms of employee benefit plans of the Company, and claims regarding reimbursements for business associated expenses the participant may have.

generic drug: A prescription drug that contains the same active ingredients, in the same dosage form, as the brand-name drug, and is subject to the same U.S. Food and Drug Administration (FDA) standards for quality, strength and purity as its brand-name counterpart.

Some generics are made by the same pharmaceutical firms that produce the brand names. Generally, generic medications cost less because they don't require the same level of sales, marketing, research and development expenses associated with brands.

group health plan: A plan that provides health care coverage and is maintained by an employer. The Employee Dental and Employee Vision Plans are considered limited scope group health plans, and the Flexible Spending Plan is considered an excepted benefit. Group health plans designated as limited scope or excepted benefits are not subject to the HIPAA Special Enrollment requirements.

home health care agency: A business that provides home health care and is licensed, approved, or certified by the appropriate agency of the state in which it is located or is certified by Medicare as a supplier of home health care.

hospice care (for the Employee Medical Plan): Care and support services given to a terminally ill person and to his or her family. An individual who is “terminally ill” has a medical prognosis of 12 months or less to live.

Hospice care enables terminally ill patients to remain in the familiar surroundings of their home for as long as they can. While benefits for necessary hospice care can be on either an inpatient or outpatient basis, about 90% of patients can be adequately treated using outpatient hospice.

To qualify for entry into a hospice program, the patient, the family and the attending physician must all accept the inevitability of the death process and relinquish all prospects of medical treatment that might aggressively prolong life, including artificial life support systems.

A **hospice care agency** is an agency that provides counseling and incidental medical services, such as room and board, for a medically ill individual, and that:

- Is approved under any required state or government Certificate of Need;
- Establishes policies governing the provision of hospice care;
- Provides an ongoing quality assurance program, which includes reviews by physicians, other than those who own or direct the agency;
- Provides 24-hours-a-day, seven-days-a-week service;
- Is under the direct supervision of a duly qualified physician;

- Has a nurse coordinator who is a registered graduate nurse with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients;
- Has a social service coordinator who's licensed in the area in which it's located;
- Provides hospice services as its main purpose;
- Has a full-time administrator; and
- Maintains written records of services given to the patient established and operated in accordance with any applicable state laws.

A hospice that's part of a hospital will be considered a hospice for the purposes of this Plan.

hospital: A short-term acute care facility which:

1. Is duly licensed as a hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a hospital provider under Medicare;
2. Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of physicians or behavioral health practitioners for compensation from its patients;
3. Has organized departments of medicine and major surgery, either on its premises or in facilities available to the hospital on a contractual prearranged basis, and maintains clinical records on all patients;
4. Provides 24-hour nursing services by or under the supervision of a registered nurse; and
5. Has in effect a Hospital Utilization Review Plan.

illness: A sickness or disease that impairs normal functions of the body. Illnesses are covered under the Plan **only** for purposes of travel assistance coverage.

Independent Review Organization (IRO): An entity that conducts independent external reviews of denied claims and appeals under federal external review procedures approved by the National Association of Insurance Commissioners. Also known as External Review Organization (ERO) by some Claims Administrators.

indexed pre-disability earnings: Your pre-disability earnings (as of the day before you begin your elimination period, plus any changes made to your pay during your elimination period). If you have been continuously receiving monthly LTD benefits under this Plan, each Jan. 1 (after you have been disabled for 12 consecutive months provided you are receiving LTD benefits at the time the adjustment is made), your pre-disability earnings (not your LTD benefit amount) are adjusted by the lesser of:

- 10%; or
- The percentage change in the Consumer Price Index (CPI), as published by the U.S. Department of Labor. The percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31, and the prior year's CPI-W as of July 31, divided by the prior year's CPI-W.

ineligible dependent: A dependent who does not meet a Plan's dependent eligibility requirements or is otherwise disqualified from eligibility.

injury (for the AD&D option under the Group Life Plan): A bodily injury directly caused by a covered accident, which is independent of all other causes, and occurs while the individual is enrolled in the Plan (insured under the insurance contract) and is not otherwise excluded under the terms of the Plan and/or the insurance contract.

investigational and/or experimental: The use of any treatment, procedure, facility, equipment, drug, device or supply not accepted as standard medical treatment of the condition being treated and any of such items requiring federal or other governmental agency approval not granted at the time services were provided. Approval by a federal agency means that the treatment, procedure, facility, equipment, drug, device or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient. Approval by a federal agency will be taken into consideration by the Claims Administrator in assessing investigational and/or experimental status but will not be determinative. As used herein, medical treatment includes medical, surgical, or dental treatment. Standard medical treatment means the services or supplies that are in general use in the medical community in the United States, and:

- Have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- Are appropriate for the hospital or facility other provider in which they were performed; and
- The physician or professional other provider has had the appropriate training and experience to provide the treatment or procedure.

The Claims Administrator shall determine whether any treatment, procedure, facility, equipment, drug, device or supply is investigational and/or experimental, and will consider factors such as the guidelines and practices of Medicare, Medicaid, or other government-financed programs and approval by a federal agency in making its determination. Although a physician or professional other provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, the Claims Administrator still may determine such services or supplies to be investigational and/or experimental within this definition. Treatment provided as part of a clinical trial or a research study is investigational and/or experimental.

IRO: See Independent Review Organization (IRO).

layoff, laid off: For the Severance Pay Plan, these terms apply if all the requirements of (1) and (2) below are met and if (3) below does not apply to the termination of employment:

- (1) Except as provided in (3) at right, the term layoff or laid off applies if:
 - (a) The Company gives the participant notice of layoff;
 - (b) The participant's employment is involuntarily terminated with the Company and with all members of the employer following such notice of layoff, on a date determined by the Company; and
 - (c) The facts are as described in (i), (ii) or (iii) below:
 - (i) The participant is not in salary grade level 21 or 22, and the termination of employment is caused by a reduction in force, a job elimination, a corporate event or is designated as a layoff by the Chief Executive Officer of ConocoPhillips Company; or
 - (ii) The participant is in salary grade level 21 or 22, and the termination of employment is designated as a layoff by the Chief Executive Officer of ConocoPhillips Company; or
 - (iii) The termination of employment is on or after a Change of Control and is either caused by a reduction in force, a job elimination, a corporate event, or designated as a layoff by the Chief Executive Officer of ConocoPhillips Company.
- (2) For purposes of (1)(c)(i) and (1)(c)(iii) above, in order for the elimination of a job other than the job currently assigned to the participant to constitute causation for the termination of the participant's employment, the relationship between the job eliminated and the job currently assigned to the participant must be as described in either subparagraph (a) or (b) below:
 - (a) The job eliminated is not lower than two levels below the level of the job currently assigned to the participant as of the date the job is eliminated, with "level" meaning salary grade levels established by the Company (or for any other salary grade or classification system used by a participating affiliate); or
 - (b) The job eliminated has weekly pay (including any pay for regularly scheduled overtime but excluding overtime due to the 19/30 program), that is at least 70% of the weekly pay (including any pay for regularly scheduled overtime but excluding overtime due to the 19/30 program) of the job currently assigned to the participant as of the date the job is eliminated. If the eliminated job is not assigned to an employee at the time of its elimination, the pay shall be the mid-point pay for the salary grade level of the eliminated job.
- (3) Provided, however, whether or not the Company has given a participant notice of layoff, the participant's termination of employment shall not be considered a layoff if any of the following apply:
 - (a) The participant resigns as of a date prior to the date specified for layoff in the notice of layoff;
 - (b) The participant's employment is terminated because he or she failed to accept, within seven calendar days of the offer, a job offered by an employer at comparable pay, at a comparable employment level, and not in the same geographical area for which he or she will receive relocation assistance;
 - (c) The participant's employment is terminated because he or she failed to accept, within seven calendar days of the offer, a job offered by an employer at comparable pay, at a comparable employment level and in the same geographical area;
 - (d) The participant's employment is terminated because he or she failed to accept, within seven calendar days of the offer, a transfer job at comparable pay offered by an affiliate that is not an employer made pursuant to a mutual agreement between the Company and the affiliate providing for such transfer job offer; or
 - (e) The participant accepts any transfer job offered by an affiliate that is not an employer made pursuant to a mutual agreement between the Company and the affiliate providing for such transfer job offer.

layoff pay: The sum of basic benefits and, if applicable, supplemental benefits a participant is entitled to receive from the Plan.

leave of absence: A direct U.S. dollar payroll status (also known as “inactive employee status”) that may or may not allow an employee to continue participation for a limited period of time in certain benefit programs for which he or she was participating as an active employee prior to going on leave of absence status.

For leaves, refer to the appropriate leave policy for a complete definition.

 “Who Is Eligible,” page M-3

legally adopted* (for the Employee Medical Plan, the Employee Vision Plan, the Employee Dental Plan, the EAP, the Houston Onsite Medical Clinic Plan and The Well Onsite Medical Clinic Plan): For a child (must be under age 18) to be considered the legally adopted son or daughter of the (i) covered employee and/or the covered employee’s eligible spouse or (ii) covered employee’s domestic partner, as applicable, a final order or final decree of adoption has been issued by a court of competent jurisdiction in the United States, and that the persons shown as the parents of the adopted child are either the (i) covered employee and/or his or her spouse or (ii) covered employee’s domestic partner, and the same person(s) are named as parents (with all state statutory parental obligations) in the decree or order evidencing the final adoption. The parent-child relationship is established when the adoption is effective and final under state law. To be legal, an adoption must be valid under the law of the state where the adoption took place. At least one party to the adoption (either the child or adopting parent) must have been domiciled or actually residing in that jurisdiction at the time of adoption. See foreign adoption for provisions if the adoption is outside the United States.

legally adopted* (for the dependent life and AD&D options under the Group Life Plan): Per the provisions of the law of the state in which you reside. Includes a child from the date of placement with adopting parents until the date of the legal adoption.

lifetime maximum (for the Employee Medical Plan): The maximum amount payable by the Plan for a covered individual throughout his or her lifetime (cumulative total among all self-insured medical options that covered the person).

maintenance medication: A prescription drug prescribed for long-term treatment of conditions such as high cholesterol or high blood pressure. Certain maintenance medications may also be considered a preventive prescription drug and, in addition, be subject to those Plan provisions. The following categories may include maintenance medications:

- Anti-infectives
- Autonomic and CNS drugs, neurology and psych
- Cardiovascular, hypertension and lipids
- Endocrine therapy
- Diabetes therapy
- Musculoskeletal and rheumatology
- Obstetric and gynecology
- Urological
- Ophthalmology
- Respiratory, allergy and cough and cold
- Hematinics and electrolytes
- Gastroenterology

Drugs on the Plan’s maintenance medication list may change, depending upon the following:

- Clinical appropriateness of dispensing the drug in larger quantities (for example, monitoring requirements, methods of administration, etc.);
- Days supply limitations (for example, state regulations, stability issues, etc.);
- Supply limitations (for example, product availability, exclusive distribution, drug recall, etc.); and
- Sensitive therapies (for example, extreme psychiatric conditions, etc.).

*** This term has multiple definitions.**

marriage and family therapist/therapy: A person who has completed the necessary education and training to meet the licensing or certification requirements of the governmental body having jurisdiction over such licensing or certification where the person renders service to a participant or dependent. Professional therapy services to individuals, families, or married couples, singly or in groups and involves the professional application of family system theories and techniques in the delivery of therapy services. Includes the evaluation and remediation of cognitive, affective, behavioral or relational dysfunction or marriage and family systems.

medically necessary* (for the Employee Medical Plan):

Those services or supplies covered under the Plan which are:

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and
2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
3. Not primarily for the convenience of the covered person, his physician, behavioral health practitioner, the hospital or the other provider; and
4. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the covered person. When applied to hospitalization, this further means that the covered person requires acute care as a bed patient due to the nature of the services provided or the covered person's condition, and the covered person cannot receive safe or adequate care as an outpatient.

The medical staff of the Claims Administrator shall determine whether a service or supply is medically necessary under the Plan and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a physician, behavioral health practitioner or other professional providers may have prescribed treatment, such treatment may not be medically necessary within this definition.

*** This term has multiple definitions.**

medically necessary* (for the Employee Dental Plan):

Services that are necessary for the diagnosis and are given at the appropriate level of care. This determination is made by the Claims Administrator. The fact that a procedure or level of care is prescribed by a dentist does not mean that it is medically necessary or that it is covered under the Plan. In certain circumstances, a medically necessary procedure may be covered partially by your medical option and not your dental coverage. In this circumstance, it may be necessary to submit a claim under both your medical and dental options. Ultimately, it is the responsibility of you and your dentist, to determine the appropriate course for dental treatment in any given case, regardless of whether it appears the Plan will pay the cost of such care.

mental health, mental health condition, mental

health disorder: A medically recognized psychological, physiological, nervous or behavioral condition affecting the brain (excluding substance use disorder or other addictive behavior) that can be diagnosed and treated by medically recognized and accepted methods.

Conditions recognized in the most current American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (5th ed. 2013) (DSM-5), or its successor publication are included in this definition.

mental illness (for the LTD Plan): A mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A mental illness may be caused by biological factors or result in physical symptoms or manifestations.

The following mental disorders, as outlined in the Diagnostic and Statistical Manual of Mental Disorders, are excluded from the mental illness limitation:

- 1) Mental Retardation;
- 2) Pervasive Developmental Disorders;
- 3) Motor Skills Disorder;
- 4) Substance-Related Disorders;
- 5) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
- 6) Narcolepsy and Sleep Disorders related to a General Medical Condition.

motor vehicle: A validly registered four-wheel private passenger car, four-wheel drive vehicle, sports-utility vehicle, pick-up truck or mini-van. It does not include any commercially licensed car, any private car being used for commercial purposes, or any vehicle used for recreational or professional racing.

negotiated rate: The maximum charge a network provider has agreed to charge for a service or supply covered by the Plan.

network deficiency: A situation in which the Claims Administrator lacks appropriate network physicians and hospitals for certain specialties or prescription drugs within a provider network.

network provider: A health care, vision or dental provider, hospital or facility in the United States that the Claims Administrator has designated as part of its provider network for the service or supply being provided. Also known as a “preferred provider.”

non-citizen, non-resident alien (also known as NCNR or non-citizen): A non-U.S. citizen or non-resident alien employee working within the U.S. under a Company-sponsored VISA and on the direct U.S. dollar payroll.

non-covered expenses: Services, treatments and diagnostic procedures not covered under the Plan.

non-emergency use of an emergency room: Treatment received in a hospital emergency room for a non-emergency while a person isn't a full-time inpatient.

non-network pharmacy: A pharmacy that's not in the prescription drug Claims Administrator's participating pharmacy network.

non-network provider (also known as non-preferred provider): A health care, vision or dental provider who has not contracted to furnish services or supplies at a negotiated rate.

nonoccupational accident: For OAD benefits under the Group Life Plan, an accident that is not considered an occupational accident. See “When OAD Benefits Are Not Paid” for further information.

 “When OAD Benefits Are Not Paid,” page I-11

nonoccupational illness or injury: An injury or illness occurring outside the workplace that is not job-related such as surgery, acute medical conditions, physician-directed absences during a pregnancy or after a birth, or due to a disease, health condition, substance use disorder, mental health condition or medical treatment and prevents an eligible employee from temporarily performing the regular duties of his or her job with the Company or other normal activities.

non-store: Employee jobs that are **not** classified in the personnel systems of the employer as retail marketing store.

notice of layoff: A written notice provided by the Company to the participant in a form acceptable to the Benefits Committee stating the date of layoff. Prior to a Change of Control, such notice is a notice of layoff only if approved by:

- The Chairman and Chief Executive Officer of ConocoPhillips Company in the case of an employee who, on the date the Company gives notice of layoff, is in salary grade levels 21 or 22;
- The Sr. Vice President of Human Resources & REFS of ConocoPhillips Company in the case of an employee who, on the date the Company gives notice of layoff, is in salary grade levels 19 or 20; or
- The Business Line Human Resources General Manager in the case of an employee who, on the date the Company gives notice of layoff, is in salary grade levels 18 or below.

occupational accident: An accident that occurs while you're performing your job duties either at your job site or while traveling on Company business (at ConocoPhillips' expense).

- The purpose of your business travel must be to further Company business, and the trip must involve a Company-authorized assignment that requires you to travel.
- Traveling on business starts when you leave from your residence, regular place of employment or other location (whichever occurs last) for the purpose of traveling to the destination of the business trip. The business trip ends when you return to or arrive at your residence or your regular place of employment (whichever occurs first).
- Everyday travel to and from work and any personal deviation does not qualify as business travel.

occupational therapy: Constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational therapy does not include educational training or services designed and adapted to develop a physical function.

other health insurance coverage: The term, as used in connection with the special enrollment rights, means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical policy or certificate, hospital or medical plan contract, or health maintenance organization contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage and individual health coverage. Certain types of coverage are not considered other health insurance coverage, such as: (i) coverage only for accident, or disability income insurance; (ii) coverage issued as a supplement to liability insurance; (iii) liability insurance; (iv) Workers' Compensation or similar insurance; (v) credit-only insurance; (vi) coverage for on-site medical clinics; (vii) Part A or Part B of Medicare; (viii) a state health benefit risk pool; (ix) medical and dental care for members and former members of the armed services; (x) medical care program of Indian Health Services or of a Tribal organization; (xi) Federal Employee Health Benefit Program; (xii) Peace Corps health plan; (xiii) public health plan (defined to be a plan of a state, county or other political subdivision); or (xiv) health coverage provided by foreign governments (e.g., Canadian health care system).

outpatient surgical facility/ambulatory surgical center: A facility (other than a hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

An "Administrator Ambulatory Surgical Facility" means an ambulatory surgical facility which has a written agreement with the Claims Administrator or another of the Claims Administrator's plans to provide services to you at the time services are rendered to you. A "Non-Administrator Ambulatory Surgical Facility" means an ambulatory surgical facility which does not meet the definition of an administrator ambulatory surgical facility.

*** This term has multiple definitions.**

own occupation (for the LTD Plan): The occupation as it is recognized in the general workplace and you are routinely performing for the Company that provides you pre-disability earnings. Own occupation does not mean the specific job you are performing at a specific location for ConocoPhillips.

participant: An employee who has met the eligibility requirements of the Plan.

personal deviation: Any travel or activity not reasonably related to the business of the Company; or not incidental to the business trip and not at the expense of the Company.

physical therapy: The treatment of a disease, injury or condition by physical means by a physician or a registered professional physical therapist under the supervision of a physician and which is designed and adapted to promote the restoration of a useful physical function. Physical therapy does not include educational training or services designed and adapted to develop a physical function.

physician* (for the Employee Medical Plan and the Employee Dental Plan): A person who:

- Has an M.D. or D.O. degree or is a health professional who under applicable insurance law is considered a physician; has medical training and clinical expertise suitable to treat your condition; specializes in psychiatry if your illness or injury is caused to any extent by alcohol abuse, substance use disorder or a mental disorder;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the person practices;
- Provides medical services which are within the scope of the person's license or certificate; and
- Is not you or related to you.

physician* (for the life and AD&D options under the Group Life Plan and LTD Plan): A person who is:

- Doctor of medicine, osteopathy, psychology or other legally-qualified practitioner of a healing art recognized by the Claims Administrator;
- Licensed to practice medicine in the jurisdiction where services are performed;
- Practicing within the scope of applicable license; and
- Not related to you by blood or marriage.

physician* (for the STD Plan): A person who:

- Has an M.D. or D.O. degree or is a health professional (such as nurse practitioners, physician assistants or other) who under applicable insurance law is considered a physician; has medical training and clinical expertise suitable to treat your condition. If your illness or injury is caused to any extent by alcohol abuse, substance use disorder or a mental disorder, the health professional includes psychiatrist, psychologist, psychiatric nurse practitioner and physician assistant.
- Is properly licensed or certified to provide medical and mental health care under the laws of the jurisdiction where the person practices;
- Provides medical and mental health services which are within the scope of the person's license or certificate; and
- Is not you or related to you.

physician assistant: A person employed by and working under the direct supervision of a covered provider (hospital, physician or clinic operated under the direction of a physician). The Plan covers services provided by a physician assistant if all of the following criteria are met:

- The charges must be billed by the hospital, physician or clinic;
- The services must be within the scope of a physician assistant's license;
- The services must be covered under the Plan; and
- The services are prescribed or recommended by a physician.

placed for adoption, placement for adoption (for the Employee Medical Plan, the Employee Vision Plan, the Employee Dental Plan, the EAP, the Houston Onsite Medical Clinic Plan and The Well Onsite Medical Clinic Plan — *does not apply to Domestic Partners*): A child (must be available for adoption and under the age of 18) has been placed for adoption with the covered employee in his or her home, whether or not the adoption has become final, as of the date of either (i) an order by a court of competent jurisdiction in the United States is issued placing the child in the home of the covered employee for the purpose of legally adopting the child and imposes a legal obligation on the covered employee for partial or total support of the child or (ii) a legally binding contract between the covered employee and an authorized placement agency has been signed by both parties that is enforceable in a court of competent jurisdiction (also known as a "placement contract"), which the placement contract places the child in the home of the covered employee for the purpose of legally adopting the child and imparts an obligation on the covered employee for partial or total support of the child.

plan year: The calendar year (Jan. 1 – Dec. 31).

post-service claim: A claim for a benefit that was not required to be preapproved before the service was received in order to get the maximum Plan benefit. Most claims under the medical, vision and dental plans will be post-service claims.

* **This term has multiple definitions.**

pre-admission testing: Preliminary tests, such as X-rays and laboratory tests, performed prior to admission on a person who is scheduled for inpatient care or outpatient surgery. Pre-admission testing must be:

- Related to the performance of a scheduled surgery that's covered by the Plan, and performed prior to, and within seven days of, surgery;
- Ordered by a physician after a condition requiring surgery has been diagnosed and after:
 - Hospital admission for the surgery has been requested by the physician and confirmed by the hospital; or
 - The surgery has been scheduled by the physician, if the surgery is to be performed on an outpatient basis; and
- Performed in a hospital or a laboratory whose tests results are determined to be acceptable by the hospital or outpatient surgical facility/ambulatory surgical center where the surgery is performed.

pre-disability earnings: Your base pay, plus regularly scheduled overtime — as determined by the Company — and as in effect on the day **before** you began your elimination period. For certain work schedules, pre-disability earnings may be calculated based on average annual working hours. Pre-disability earnings may include:

- Any pay increases you receive during the elimination period; and
- Contributions you make through a salary reduction agreement with the Company to any of the following:
 - An Internal Revenue Code (IRC) Section 401(k) plan;
 - An executive nonqualified deferred compensation arrangement; and
 - Amounts contributed under an IRC Section 125 plan.

Pre-disability earnings do **not** include:

- Overtime resulting from the 19/30 work schedule;
- Unscheduled overtime, upgrade pay, holiday pay, allowances, shift differential and callout pay;
- Awards, commissions and bonuses;
- Grant, award, sale, conversion and/or exercise of shares of stock or stock options, including, but not limited to, the grant, award, transfer, exercise and/or lapse of restrictions of qualified or nonqualified stock options, restricted stock, restricted stock units, phantom stock, stock appreciation rights, performance share units or any other form of equity-type compensation;

- Contributions made by the Company on your behalf to any deferred compensation arrangement or pension plan; and
- Any other compensation.

pre-existing condition (for the LTD Plan): An accidental bodily injury, sickness, mental illness, substance abuse or pregnancy (includes any manifestations, symptoms, finds or aggravations relating to or resulting from any of these conditions) for which you have received medical treatment, consultation, care or services during the 90-day period that ends the day before your effective date of coverage or change in coverage.

pre-service claim: A claim for a benefit that is required to be preapproved before the service is received in order to get the maximum Plan benefit. This includes such things as required pre-authorization, case management or utilization review, and requests to extend a course of treatment that was previously preapproved.

preventive medical care: A medical examination or service given by a provider when the “intent” of the visit is not in connection with the diagnosis, monitoring or treatment of a suspected or identified disease or injury. “Not in connection” means you have never been treated, diagnosed or suspected to have the identified disease or condition for which the provider is giving the examination or service. Preventive medical care includes screening and counseling services for obesity, misuse of alcohol and/or drugs and use of tobacco products. Preventive medical care also refers to services based on the preventive medical care guidelines followed by the medical Claims Administrator. These guidelines may be based on recommendations from nationally recognized organizations, such as the U.S. Preventive Services Task Force. **Note:** Certain drugs such as aspirin, immunizations and contraceptives, if prescribed by a physician and meet the Health Care Reform eligibility criteria, are also included and are administered by the prescription drug Claims Administrator. See hr.conocophillips.com for preventive care information or call the Benefits Center for a free paper copy of the information.

 “Contacts,” page A-1

preventive prescription drugs: Prescription drugs that help avoid or prevent reoccurrence of an illness or condition. Some prescription drugs that control an illness or condition may be included and drugs within the category may change periodically. The Claims Administrator sets preventive prescription drug medications clinical dispensing guidelines. Certain preventive prescription drugs may also be considered a maintenance medication and, in addition, be subject to those Plan provisions. **Note:** Certain drugs such as aspirin, immunizations and contraceptives, if prescribed by a physician and meet the Health Care Reform eligibility criteria, are considered preventive medical care and are administered by the prescription drug Claims Administrator. See hr.conocophillips.com for further details and for the preventive prescription drug list or call the Benefits Center for a free paper copy of the information.



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primary care physician (PCP): A physician responsible for coordinating all care for an individual patient — from providing direct care services to referring the patient to specialist and hospital care when necessary.

principal sum: The total amount of AD&D benefit purchased by you and from which certain AD&D benefits are calculated.

professional counselor: A person who has completed the necessary education and training to meet the licensing or certification requirements of the governmental body having jurisdiction over such credentialing where the person renders service to a patient.

psychiatrist: A physician who specializes in the prevention, diagnosis, and treatment of mental illness and substance use disorders. A psychiatrist:

- Must be licensed to practice psychiatry in the state in which the services are being provided;
- Must receive additional training and serve a supervised residency in his or her specialty;
- May also have additional training in a psychiatric specialty, such as child and adolescent psychiatry, geriatric psychiatry, and/or psychoanalysis; and
- May prescribe medication.

psychologist: A person who is:

- Licensed or certified as a clinical psychologist by the appropriate governmental authority having jurisdiction over such licensing or certification in the jurisdiction where the person renders service to the patient; or
- A member or fellow of the American Psychological Association if there's no licensing or certification in the jurisdiction where the person renders service to the patient.

reasonable and customary* (for the Employee Medical Plan): Benefits are paid based on reasonable and customary limits (not applicable to charges by a network provider). Generally, the reasonable and customary limit is the prevailing charge for the same service among providers in the same geographic area.

In no event shall the term reasonable and customary be defined as exceeding 150% of the prevailing rate paid by Medicare for the same service within the same geographic area.

In determining prevailing charge, the Claims Administrator maintains data for its use in processing claims. The Plan sets the percentile for the reasonable and customary fee. **Note:** The Claims Administrator uses an outside profile data source to ensure that there's adequate profile information to support reasonable and customary benefit determination. The charges received for a given procedure in a specific ZIP code are all grouped and then ranked.

For a medically necessary service or supply, the reasonable and customary limit is generally the lowest of:

- The charge the Claims Administrator determines to be appropriate based on such factors as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- The charge the Claims Administrator determines to be the reasonable and customary percentage made for that service or supply capped at 150% of the Medicare rate for the same service. If you receive non-network services from radiologists, anesthesiologists and pathologists, an exception may be made if you received those services at a network facility. Exceptions may also be made in the event of emergency care.

In determining the recognized charge for a service or supply that's unusual, not often provided in the area or provided by only a small number of providers in the area, the Claims Administrator may take into account such factors as the:

- Complexity;
- Degree of skill needed;
- Type of specialty of the provider;
- Range of services or supplies provided by a facility; and
- Reasonable and customary charge made by providers in other areas.

If no reasonable and customary limits can be determined using these methods the Claims Administrator may cap the recognized charges at 50% of billed charges.

In some circumstances, the Claims Administrator may have an agreement with a provider (either directly or indirectly through a third party) that sets the rate that the Plan will pay for a service or supply. In these instances, in spite of the methodology described above, the recognized charge is the rate established in such agreement.

Example of Covered Charge

If the provider charges:	And the prevailing charge (reasonable and customary) by providers in the area is:	The plan will recognize:
\$50	\$55	\$50
\$60	\$55	\$55

The Plan does NOT cover charges that are over the reasonable and customary limit. In addition, charges that are over the reasonable and customary limit don't count toward satisfying any annual deductible or annual out-of-pocket maximum that may apply to your medical plan.

In order for the Plan to recognize a provider's fee above the reasonable and customary level as a covered expense, there must be an appeal to the Claims Administrator that verifies that there was something out of the ordinary that warrants the higher charge.

* **This term has multiple definitions.**

To find out whether your provider's charges fall within reasonable and customary limits for a specific service before you receive care, ask your provider for:

- The amount of the charge;
- The numeric code that your provider will assign to the service provided; and
- Your provider's billing office ZIP code.

You should call the Claims Administrator with this information well in advance of receiving the service. The Claims Administrator will let you know whether the charges are within reasonable and customary limits.

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reasonable and customary* (for the *Employee Dental Plan and the Flexible Spending Plan*): The dollar amount that is the lower of the provider's charge or the prevailing charge for the same service among providers in the same geographic area is the reasonable and customary amount. **Note:** Dental charges that are over the reasonable and customary limit don't count toward satisfying any annual deductible or annual maximum benefit that may apply to the Employee Dental Plan.

reasonable driving distance: The network radius is 50 miles from your home as determined by the Claims Administrator.

referral: The process of increasing client awareness of various available resource systems as well as expediting transfer of the client to the appropriate resource.

rehabilitation program: A process of working with the Claims Administrator in order for them to plan, adapt and put into use options and services to meet your return to work needs. A rehabilitation program may include, when the Claims Administrator deems appropriate, necessary and feasible:

- 1) Vocational testing;
- 2) Vocational training;
- 3) Alternative treatment plans such as:
 - a) Support groups;
 - b) Physical therapy;
 - c) Occupational therapy; or
 - d) Speech therapy;

*** This term has multiple definitions.**

- 4) Workplace modification to the extent not otherwise provided;
- 5) Job placement;
- 6) Transitional work; and
- 7) Similar services.

related (for the STD Plan): Refers to a disability that is result of or caused by another prior disability. Can be same as prior disability only if it was direct result of that prior disability or the prior disability had not fully been terminated. A related disability will be considered the same claim as the original disability and will not require a separate STD waiting period if occurring within the same calendar year as the original disability. Documentation provided within an Employee Health Report will be used to determine if a disability is related or unrelated to any prior disability.

Release: See "General Release of Liability (Release)" in this Glossary.

relocation assistance: Reimbursement to the participant by the Company of moving expenses under the Company's current moving policy.

rescind or **rescinded** or **rescission:** A retroactive cancellation or discontinuance of coverage.

Reserve National Guard Service: Includes:

- Attending or en route to or from any active duty training of less than sixty (60) days;
- Attending or en route to or from a service school of any duration;
- Taking part in any authorized inactive duty training; or
- Taking part as a unit member in a parade or exhibition authorized by official orders.

resident alien: You are a resident alien as of the first date you are or may be treated as a resident alien as defined by the IRS. Generally, you must satisfy either the "green card test" or the "substantial presence test" to be treated as a resident alien. For more information, see IRS Publication 519 "U.S. Tax Guide for Aliens."

residential treatment center: A facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include halfway houses, wilderness programs, supervised living, group homes, boarding school/houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24-hour medical availability and 24-hour onsite nursing service for mental health and/or for treatment of substance use disorders. The Claims Administrator requires that any facility providing treatment of mental health and/or substance use disorders must be licensed in the state where it is located, or accredited by a national organization that is recognized by the Claims Administrator as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy. A residential treatment center that's part of a hospital will be considered to be a residential treatment center for the purposes of this program.

Residential treatment center for children and adolescents means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provisions of Mental Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

Residential treatment centers are defined differently for the two types of treatment, as shown below.

For Mental Health Treatment

Residential Treatment Facility (Center) Services (RTCS) are provided to individuals who require 24-hour treatment and supervision in a safe therapeutic environment. RTCS is a 24-hours-a-day/seven-days-a-week facility-based level of care. RTCS provides individuals with severe and persistent psychiatric disorders therapeutic intervention and specialized programming in a controlled environment that includes a high degree of supervision and structure. RTCS addresses the identified problems through a wide range of diagnostic and treatment services, as well as through training in basic skills, such as social skills and activities of daily living that cannot be provided in a community setting. This treatment primarily provides social, psychosocial and rehabilitative training, and focus on family or caregiver reintegration. Active family/significant involvement through family therapy is a key element of treatment and is strongly encouraged unless contraindicated.

For Substance Use Disorder Treatment

A facility that:

- Is established and operated in accordance with any applicable state law to provide a program of medical and therapeutic treatment for alcoholism or drug abuse;
- Provides a defined program of treatment for substance use disorder and/or behavioral health;
- Has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient; and
- Provides at least the following basic services:
 - Room and board;
 - Evaluation and diagnosis;
 - Counseling; and
 - Referral and orientation to specialized community resources.

room and board charges: Covered charges at a semiprivate room rate (if a facility only has private rooms, the billed charge is allowed), excluding physician services or intensive nursing care. Room and board charges include:

- All charges for medical care and treatment that are made by a hospital at a daily or weekly rate for room and board; and
- Other hospital services and supplies that are regularly charged by the hospital as a condition of occupancy of the class of accommodations occupied.

same geographical area: A new job is considered in the same geographical area as a current job if the distance between the participant's primary residence, as of the date notice of layoff is given, and the location of the new job is no more than the IRC-determined number of miles greater than the distance between the participant's primary residence, as of the date notice of layoff is given, and the location of the current job. For this purpose the "IRC-determined number of miles" is determined with reference to Code section 217(c)(1)(A) or successor Code section and final regulations pertaining to that Code section as in effect on the date of layoff.

school: School includes elementary schools, junior and senior high schools, colleges, universities, and technical, trade and mechanical schools that maintain a regular faculty and curriculum and has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on. It doesn't include on-the-job training courses, correspondence schools and night schools.

seat belt: Any restraint device that meets published United States Government safety standards, is properly installed by the car manufacturer; and is not altered after the installation. It includes any child restraint device that meets the requirements of applicable state law.

service in the uniformed services: The performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including:

- Active duty;
- Active duty for training;
- Initial active duty for training;
- Full-time National Guard duty;
- A period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties;
- A period for which a person is absent from employment to perform certain funeral honors duty; and
- Certain duty and training by intermittent disaster relief personnel for the Public Health Service.

skilled nursing facility: A facility setting offering a defined course of therapeutic intervention and skilled nursing and is licensed by the appropriate state and local authority to provide such service. It does not include halfway houses, wilderness programs, supervised living, group homes, boarding school/houses or other facilities that provide primarily custodial care. The facility must be eligible as a Medicare or Medicaid supplier of skilled nursing care. Patients are medically monitored with 24-hour medical availability and 24-hour onsite nursing service.

social worker: A person who:

- Is licensed or certified as a social worker by the appropriate governmental agency having jurisdiction over such licensing or certification in the jurisdiction where the person renders service; or
- Is a member of the Academy of Certified Social Workers of the National Association of Social Workers, if there's no licensing or certification in the jurisdiction where such person renders service.

solid organ: Organs — including the heart, lungs, pancreas, bone marrow/stem cell and liver. The Blue Distinction Centers program is designed to help arrange covered care for these solid organ and tissue transplants.

spinal manipulation (also chiropractic): Services that adjust spinal disorders; includes manipulative (adjustive) treatment or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine. Services cannot be considered short-term therapy or rehabilitation benefits.

spouse (for the Severance Pay Plan): A spouse is:

- One of the parties of a legally valid marriage pursuant to state and federal law; or
- One of the parties to a common law marriage if the common law marriage was consummated in a state that recognizes common law marriages and all the state requirements were met with marriage.

STD absence: Absences due solely to an employee's sickness, examinations or treatment due to a disability and/or nonoccupational illness or injury during such period of time as the employee would have otherwise been performing regularly scheduled work. STD absences also include physician-directed absences during or after a pregnancy which begin the date the physician determines the employee is no longer able to work and ends the latter of 320 hours immediately following the birth or when the physician releases the employee to return to work. STD absences do not include routine wellness or diagnostic examinations.

substance abuse (for the LTD Plan): The pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by: 1) impairments in social and/or occupational functioning; 2) debilitating physical condition; 3) inability to abstain from or reduce consumption of the substance; or 4) the need for daily substance use to maintain adequate functioning. Substance includes alcohol and drugs but excludes tobacco and caffeine.

substance use disorder (SUD): A condition or disorder that falls under any of the substance use disorder diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

substantial supervision: The presence of another individual for the purpose of protecting you from harming yourself or others.

successor employer: One or more unrelated entity(ies) that:

- Purchases assets from the Company or from a member of the employer; **or**
- Subsequently purchases assets from a successor employer as defined in the item above where such subsequent purchase is in connection with a corporate event; **or**
- Purchases stock of an entity from the Company or from a member of the employer; **or**
- Forms a joint venture with the Company or with a member of the employer; **or**
- Purchases an interest in a joint venture from the Company or a member of the employer; **or**

- Assumes the role of operator of a joint venture or business for which the Company had been the operator just prior to that assumption; **or**
- Provides service to the employer that was formerly provided by employees of the Company or a member of the employer and that offers employment to one or more participants in connection with a corporate event; **or**
- Is designated by the Vice President of Human Resources as a successor employer.

support (for the Employee Medical Plan, the Employee Vision Plan, the Employee Dental Plan, the Flexible Spending Plan, the EAP, the Houston Onsite Medical Clinic Plan and The Well Onsite Medical Clinic Plan):

Refers to providing more than one-half support of an individual's total support. To make this determination, you must compare the amount of support you provide with the amount of support the other individual receives from all sources, including Social Security, welfare payments, the support you provide and the support the individual supplies for himself or herself.

Support includes items and services such as food, shelter, clothing, medical and dental care and education. For an eligible child who's a full-time student, scholarships received for study at a school are excluded from the support test. For an eligible child who's disabled, income received for the performance of services at a sheltered workshop are excluded from the support test, provided the:

- Availability of medical care is the main reason the disabled child is at the workshop; and
- Income comes solely from activities at the workshop that are incidental to medical care.

If you believe you might provide more than one-half of an individual's support, you should use the support worksheet in IRS Publication 501 (Exemptions, Standard Deduction and Filing Information).

terminally ill (for the life option under the Group Life Plan): Certified by a physician as having a life expectancy, due to illness, of 24 months or less.

termination date: The last day of an employee's employment as recorded in the Company's personnel records. Was known as employment end date in Plans prior to Jan. 1, 2025.

tobacco free: Using tobacco products, such as smokeless tobacco, cigars, cigarettes, electronic cigarettes or other products that contain nicotine, one time or less a month, for the past six months or at the time of your certification you completed a tobacco cessation program during the current calendar year.

transitional duty: A position that has less than the full-time work schedule you had prior to your disability or does not have all the duties of the job you had prior to your disability and that has been approved by your supervisor and been made available to you.

uniformed services: The Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty (i.e., pursuant to order issued under United States federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the president in time of war or national emergency.

unrelated (for the STD Plan): Refers to a disability that is not due to or caused by a prior disability. Can be same as a prior disability but is not related if the prior disability had been fully terminated. An unrelated disability will be considered a separate claim and require a separate STD waiting period. Documentation provided within an Employee Health Report will be used to determine if a disability is related or unrelated to any prior disability.

unrelated entity: A person, company or other legal entity that is not in the affiliated group.

urgent care: Services that are medically necessary and immediately required because of a sudden illness, injury or condition that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

urgent care claim: A pre-service claim in a situation where delaying a decision on the claim until the usual deadline:

- Could seriously jeopardize your life or health or your ability to regain maximum function; or
- Would, in the opinion of a physician who knows your medical condition, subject you to severe and unmanageable pain.

The Employee Medical Plan, Employee Vision Plan and Employee Dental Plan will treat a claim as an urgent care claim if the physician or dentist treating you advises the Plan that the claim satisfies the urgent care criteria. Whether a claim meets the urgent care criteria is determined at the time the claim is being considered.

USERRA: The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended. This is a federal act that provides for continuation of coverage for employees and covered dependents who, under certain circumstances related to uniformed service, would otherwise lose their group health coverage.

U.S. expatriate (expat): An employee on the direct U.S. dollar payroll working for the Company outside the United States on a temporary assignment and designated by the Company as a U.S. expatriate.

valid beneficiary designation: Under the Group Life Plan options, a Claims Administrator-approved form for the applicable Plan that's completed either online at <http://hr.conocophillips.com/contacts-resources/mybenefits> or when the required information is given by phone to the Benefits Center. A designation by an absolute assignee is valid only after a form provided by the Benefits Center is completed with all the required information.

vision screening: A short examination that can indicate potential vision problems that may require a follow up appointment with a specialized vision health care provider.

walk-in clinic: Free-standing health care facilities, typically staffed by nurse practitioners and/or physician assistants, also have a physician on call during all hours of operation and provide limited primary care for unscheduled, non-emergency illnesses and injuries and certain immunizations, as an alternative to a physician's office visit. Walk-in clinics are not designed to be an alternative for emergency room services, ongoing care provided by a physician or services by the outpatient department of a hospital.

week's pay, weekly pay: If a participant is a salaried employee, the participant's weekly pay is equal to the participant's regular monthly base salary rate at the date of layoff divided by 4.3333. A participant's regular monthly base salary rate shall not include bonuses, incentive pay, variable pay or other special or premium pay.

If a participant is an hourly-paid employee, the participant's weekly pay is equal to the participant's regular base pay rate for the participant's regularly scheduled workweek, including any pay for regularly scheduled overtime but excluding overtime due to the 19/30 work schedule, as of the date of layoff. A participant's regular base pay rate shall not include shift differentials, temporary or irregular overtime payments, bonuses, incentive pay, variable pay, or any other special or premium pay.

For an employee whose weekly hours vary based on a rotational schedule, weekly pay shall equal their annual pay divided by 52.

Further, weekly pay shall be determined without regard to reduction for base military pay received while on military leave and without regard to reductions for state-paid disability payments or workers' compensation payments.

well vision exam: A comprehensive eye examination to evaluate and treat vision problems and related diseases.

work days:

- **Hourly employees:** Regularly scheduled working days.
- **Salaried employees:** Days that they are normally and regularly expected to work.

Working Aged Provision: Part of the Social Security Act that affects active employees age 65 and older and dependent spouses/domestic partners age 65 and older. All medical benefits to which you and your covered spouse/domestic partner are entitled under the Employee Medical Plan will be paid before any payments under Medicare, unless and until you or your spouse/domestic partner rejects, in writing, coverage for the benefits under the Plan. If you have rejected coverage under the Plan while you were still employed, your spouse/domestic partner will not be covered or entitled to benefits under the Plan. If coverage for the health benefits under the Plan is elected, benefits will be in accordance with the medical option in which you're enrolled.

The Working Aged Provision doesn't affect retirees or their dependents. Nor does it affect participants who terminated employment and who have been approved for continued benefits under the Long-Term Disability Plan.

workweek:

- **For hourly employees:** The number of regularly scheduled hours in a period of seven consecutive days during which the employee is normally and regularly scheduled to be at work.
- **For salaried employees:** The number of days in a period of seven consecutive days during which the employee is normally and regularly expected to be at work.

Note: Number of hours and days may vary due to work schedules that are not 40 hours per week and/or 8 hours per day.

years of service (for the Severance Pay Plan): The full years of recognized continuous service, from the participant's company service date, or from the participant's Severance Service Date (SSD) if applicable, to the date of layoff, with the company service date, SSD and the years of recognized continuous service determined under the Service Recognition Policy of the Company, provided, however, that for a participating affiliate that does not use such terms, equivalent dates under the usage of the participating affiliate. However, after the participant has reached his or her first anniversary date, the participant's service will be recognized up to the anniversary date (if such date is after the participant's date of layoff) in the calendar year in which the participant is laid off.

