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

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p><b>In-Network:</b>                      \$1,500 Individual                      \$4,500 Family                      Includes medical and prescription drug costs. Does not apply to preventive care <a href="#">in-network</a>.</p>	<p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of the <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes, preventive care- routine physical exams</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p><b>Yes. In-Network:</b>                      \$5,000 Individual                      \$10,000 Family                      Includes medical and prescription drug costs.</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket</a> limits until the overall family <a href="#">out-of-pocket</a> limit has been met.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p>Premiums, <a href="#">balance-billed</a> charges, penalties for failure to obtain <a href="#">pre-authorization</a> for services, health care this <a href="#">plan</a> doesn't cover, and charges in excess of reasonable and customary amounts as defined in the <a href="#">plan</a> document.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes. For a list of <a href="#">in-network</a> providers, see <a href="http://www.aetna.com">www.aetna.com</a> or call 1-800-738-7674.</p>	<p>This <a href="#">plan</a> uses a <a href="#">provider network</a>. You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a>. You will pay the most if you use an <a href="#">out-of-network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (<a href="#">balance billing</a>). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for</p>

		some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a referral.

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a> or by calling 1-855-293-4118.</p>	Generic drugs	<b>Retail:</b> \$10 copay <b>Mail/Maintenance Choice:</b> \$20 copay	\$10 copay plus any amount above the negotiated/discounted rate.	Retail covers up to a 30-day supply.  Mail order/Maintenance Choice covers up to a 90-day supply.  You pay 100% of the difference in cost if you obtain a brand name drug when a generic brand is available.
	Preferred brand drugs	<b>Retail:</b> 40% <u>coinsurance</u> ; \$40 minimum <u>coinsurance</u> / \$240 maximum <u>coinsurance</u> <b>Mail/Maintenance Choice:</b> 40% <u>coinsurance</u> ; \$100 minimum <u>coinsurance</u> / \$600 maximum <u>coinsurance</u>	40% <u>coinsurance</u> plus amounts above the negotiated/discounted rate.	You pay 100% of the cost for maintenance medications if not obtained via mail order / Maintenance Choice after the second refill.
	Non-preferred brand drugs	<b>Retail:</b> 50% <u>coinsurance</u> ; \$80 minimum / \$480 maximum <u>coinsurance</u> <b>Mail/Maintenance Choice:</b> 50% <u>coinsurance</u> ; \$200 minimum <u>coinsurance</u> / \$1,200 maximum <u>coinsurance</u>	50% <u>coinsurance</u> plus amounts above the negotiated/discounted rate.	You pay the full price and then file a claim if using a <u>non-network provider</u> .  Certain drugs may require <u>pre-authorization</u> or are subject to utilization rules.
	<a href="#">Specialty drugs</a>	<b>Retail:</b> 40% <u>coinsurance</u> ; \$40 minimum <u>coinsurance</u> / \$240 maximum <u>coinsurance</u> <b>Mail/Maintenance Choice:</b> 40% <u>coinsurance</u> ; \$100 minimum <u>coinsurance</u> / \$600 maximum <u>coinsurance</u>	40% <u>coinsurance</u> plus amounts above the negotiated/discounted rate.  You pay 100% of the cost of injectable medications obtained <u>out-of-network</u>	Prescriptions for certain self-injectable and oral medications must be submitted to prescription drug claims administrator.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u> , subject to <u>allowed amount</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u> , subject to <u>allowed amount</u>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <u>coinsurance</u> for emergency 50% <u>coinsurance</u> for non-emergency	20% <u>coinsurance</u> for emergency 50% <u>coinsurance</u> for non-emergency, subject to <u>allowed amount</u>	None
	<a href="#">Emergency medical transportation</a>	20% <u>coinsurance</u> for emergency	20% <u>coinsurance</u> , subject to <u>allowed amount</u>	None
	<a href="#">Urgent care</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u> , subject to <u>allowed amount</u> ,	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u> , subject to <u>allowed amount</u>	<u>Pre-authorization</u> may be required. Benefits will be reduced by \$200 if <u>non-network hospital pre-authorization</u> is not obtained.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u> , subject to <u>allowed amount</u>	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u> , subject to <u>allowed amount</u>	<u>Pre-authorization</u> may be required for non-emergency situations. Managed by Beacon Health Options.
	Mental/Behavioral health inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u> , subject to <u>allowed amount</u>	
	Substance use disorder outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u> , subject to <u>allowed amount</u>	
	Substance use disorder inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u> , subject to <u>allowed amount</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u> , subject to <u>allowed amount</u>	None
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u> , subject to <u>allowed amount</u>	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% <u>coinsurance</u> , subject to <u>allowed amount</u>	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u> , subject to <u>allowed amount</u>	Coverage is limited to 120 visits per calendar year. <u>Pre-authorization</u> required for non-network care. Benefits will be reduced by \$200 if <u>pre-authorization</u> is not obtained.
	<a href="#">Rehabilitation services</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u> , subject to <u>allowed amount</u>	None
	<a href="#">Habilitation services</a>	Not covered	Not covered	None
	<a href="#">Skilled nursing care</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u> , subject to <u>allowed amount</u>	Coverage is limited to 60 days per calendar year. <u>Pre-authorization</u> required for <u>non-network</u> care. Benefits will be reduced by \$200 if <u>pre-authorization</u> is not obtained.
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u> , subject to <u>allowed amount</u>	None
	<a href="#">Hospice services</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u> , subject to <u>allowed amount</u>	<u>Pre-authorization</u> required for <u>non-network</u> care. Benefits will be reduced by \$200 if <u>pre-authorization</u> is not obtained
If your child needs dental or eye care	Children's eye exam	No charge if performed as part of a preventive health visit.	Not covered	None
	Children's glasses	Discounts available	Not covered	See your policy or <u>plan</u> for additional coverage options.
	Children's dental check-up	Not covered	Not covered	None

### Excluded Services & Other Covered Services:

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

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li><li>• Glasses</li></ul> | <ul style="list-style-type: none"><li>• Habilitation services</li><li>• Hearing aids</li><li>• Long-term care</li></ul> | <ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul> |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|--|---|---|
| <ul style="list-style-type: none"><li>• Acupuncture (if medically necessary or in lieu of anesthesia)</li><li>• Bariatric surgery (<a href="#">pre-authorization</a> required)</li><li>• Chiropractic care</li></ul> | <ul style="list-style-type: none"><li>• Infertility treatment (includes artificial insemination and in-vitro fertilization up to \$10,000 lifetime maximum)</li></ul> | <ul style="list-style-type: none"><li>• Private-duty nursing (limit combined with Home health care visitation)</li><li>• Non-emergency care when traveling outside the U.S.</li></ul> |
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**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact [hr.conocophillips.com](http://hr.conocophillips.com) or call 1-800-622-5501. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### Does this plan provide Minimum Essential Coverage? Yes

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

### Does this plan meet the Minimum Value Standards? Yes

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

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-622-5501.

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

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

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

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

About these Coverage Examples:



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

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist](#) [coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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

<b>Total Example Cost</b>	<b>\$12,840</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$40
Coinsurance	\$2,220
<i>What isn't covered</i>	
Limits or exclusions	\$100
<b>The total Peg would pay is</b>	<b>\$3,860</b>

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist](#) [coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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

<b>Total Example Cost</b>	<b>\$7,460</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$310
Coinsurance	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$210
<b>The total Joe would pay is</b>	<b>\$3,820</b>

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist](#) [coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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

<b>Total Example Cost</b>	<b>\$2,010</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,590</b>