

2027 U.S. Expatriate Benefit Highlights

Note: Changes for 2026 are shown in **bold**.

	Network (In the U.S.)	Non-Network (In the U.S.)	Outside the U.S.
Cost Sharing			
Annual deductible	\$1,750 You Only \$3,500 Other coverage levels	\$3,500 You Only \$7,000 Other coverage levels	None
Out-of-pocket maximum	\$4,500 You Only \$9,000 Other coverage levels	\$9,000 You Only \$18,000 Other coverage levels	None
Lifetime coverage limit	No limit	No limit	No limit
Medical Services			
Preventive Care	100% covered	60% covered after deductible	100% covered
Office visits	80% covered after deductible	60% covered after deductible	100% covered
Inpatient & Outpatient Services	80% covered after deductible	60% covered after deductible	100% covered
Emergency room	80% covered after deductible	80% covered after deductible	100% covered
Hearing Aids <i>Maximum: 1 aid per ear every 36 months up to \$1,000</i>	80% covered	60% after deductible	100% after deductible
Infertility Treatment	80% covered after deductible	60% covered after deductible	100% covered
Mental Health & Substance Use Disorder Services	80% covered after deductible	60% covered after deductible	100% covered
Speech Therapy	80% covered after deductible	60% covered after deductible	100% covered

Prescription Drugs			
Certain preventive care medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no copayment or deductible, when purchased from a Network Pharmacy. A written prescription is required.			
Retail Pharmacy Home Delivery – 30 or 90-day supplies			
	Network (In the U.S.)	Non-Network (In the U.S.)	Outside the U.S.
Generic Preventive	100% covered	60% covered, deductible not applicable	100% covered
Other*	80% covered	60% covered, deductible not applicable	100% covered

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

Dental Services	
Annual Deductible	\$50 You Only \$150 Other coverage levels
Class 1: Preventive Services	100% covered
Class 2: Basic Services	80% covered after deductible
Class 3: Major Services	50% covered after deductible
Class 4: Orthodontia	50% covered after deductible; \$2,000 per person lifetime maximum benefit
Class 5: Implants	50% covered after deductible
Plan Limits	
Annual maximum benefit	\$2,000 per person (limit is combined for Class 1, 2, 3 and 5)

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

2026 Monthly Employee Cost	
Coverage Tier	Monthly Premium
You Only	\$111.19
You + Child	\$200.13
You + Spouse	\$244.62
You + Children	\$233.57
You + Family	\$333.57

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