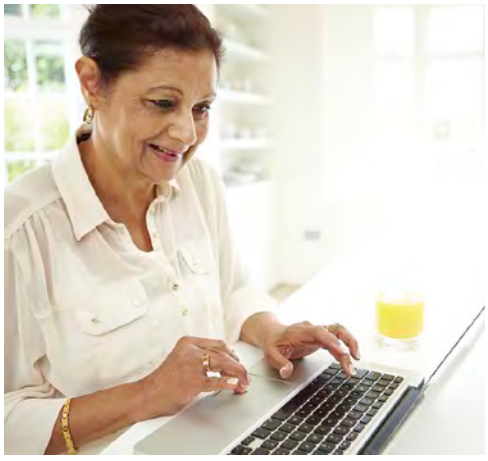
ConocoPhillips

2025 Retiree Benefits Handbook

Effective January 1, 2025

Welcome

This handbook is the Summary Plan Description (SPD) for the ConocoPhillips retiree 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 retirees 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 current 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. The Appendices of this handbook contains details of certain historical official plan provisions. 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 Retiree Benefits Handbook

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

But remember, it's your responsibility to make sure you understand your benefits and use them wisely. This easy-to-use handbook, which features important information about our retiree 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 retiree benefits is available on *hr.conocophillips.com*.

Contacts

A

Plan Administration

For Information on:	Contact/Address	Phone/Operating Hours
Medical Benefits *(Applies for all retirees eligible for Retiree Medical Pre-Age 65)* • Eligibility criteria to participate • Enrollment, changing coverage • Changing personal information (including dependent information) • Payment of premiums • Qualified Medical Child Support Orders (QMCSO)	Benefits Center P.O. Box 770 Monroe, WI 53566-0770 **Web:** • 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
Medical Benefits *(Applies for all retirees eligible for Retiree Medical Age 65 and Over)* • Eligibility criteria to participate • Enrollment, changing coverage • Changing personal information • Payment of premiums	**Web:** *https://retiree.uhc.com/conocophillips*	(855) 323-1665 8:00 a.m. to 8:00 p.m. local time, Monday – Friday (calls outside of these hours will be routed for after-hours self-service) TTY/TDD 711 *Fax:* (888) 836-3985
Dental Benefits *(Applies for all retirees eligible for retiree medical benefits)* • Eligibility criteria to participate • Enrollment, changing coverage • Changing personal information (including dependent information) • Payment of premiums	UnitedHealthcare Dental Attn: M/S CA 120-0451 P.O. Box 6020 Cypress, CA 90630-0020 **Web:** *www.myuhc.com* **Email:** *SG13001@uhc.com*	(800) 996-7563 7:00 a.m. to 10:00 p.m. Central time, Monday – Friday *Fax:* (844) 608-0601
Life • Eligibility criteria to participate • Enrollment, changing coverage • Changing personal information (including dependent information) • Coverage amounts • Payment of premiums	Benefits Center P.O. Box 770 Monroe, WI 53566-0770 **Web:** • 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

COBRA Administration

For Information on:	Contact/Address	Phone/Operating Hours
Continuing your medical benefits	Benefits Center P.O. Box 770 Monroe, WI 53566-0770 **Web:** • 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 G-20
- See "Plan Administration" for descriptions of the Benefits Committee's rights and responsibilities and its contact information.

  "Plan Administration," page G-4

Retiree Medical – Pre-Age 65

For Information on:	Contact/Address	Phone/Operating Hours
You should contact the appropriate parties identified below if you have questions about: • Network providers • Covered and non-covered expenses • ID cards • Claims • Network deficiency		
Medical Benefits *HDHP and HDHP Base (Blue Choice PPO network) Options*	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) *(for self-service)* Blue Distinction Centers *(for transplants, cardiac, orthopedic, bariatric procedures)* Well-Being Management* *(health-management service on complex conditions to lifelong wellness)* Blue365™ *(access to health & wellness products/services)* Network Deficiency *(medical network provider not available)* ** Not available to participants on Medicare.*	(800) 343-4709 7:00 a.m. to 9:00 p.m. Central time, Monday – Friday (calls outside of these hours will be routed for after-hours self-service)
	MDLive *(for physician telephone medical consultation)* **Web:** *https://members.mdlive.com/bcbstx*	(888) 680-8646 24 hours/day, 365 days/year
	2nd MD *(for medical second opinions)* **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 *(for traveling outside the U.S.)* **Web:** *bcbsglobalcore.com*	(800) 810-2583 24 hours/day, 365 days/year *Outside the U.S.:* (804) 673-1177 *(call collect)* 24 hours/day, 365 days/year

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For Information on:	Contact/Address	Phone/Operating Hours
Prescription Drug Benefits	CVS Caremark™ Claims Administrator P.O. Box 52136 Phoenix, AZ 85072-2136 **Web:** *hr.conocophillips.com* or *www.caremark.com* *www.cvsspeciality.com*	(855) 293-4118 24 hours/day, 365 days/year *For Specialty Pharmacy:* (800) 237-2767 6:30 a.m. to 8:00 p.m. Central time, Monday – Friday *For ExtraCare Health Card:* (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 *Fax:* (918) 662-3455

Retiree Medical – Age 65 and Over

For Information on:	Contact/Address	Phone/Operating Hours
• Covered and non-covered expenses • ID cards • Claims • Network providers • Telephonic Nurse Support • Wellness programs • House Calls • ReNew Active • Stay Health At Home	*For medical claims:* UnitedHealthcare Insurance Company P.O. Box 31362 Salt Lake City, UT 84131-0362 **Web:** *https://retiree.uhc.com/conocophillips* *For prescription drug claims:* OptumRx P.O. Box 650287 Dallas, TX 75265-0287	*For Members:* (855) 323-1665 8:00 a.m. to 8:00 p.m. local time, Monday – Friday (calls outside of these hours will be routed for after-hours self-service) TTY/TDD 711 *For Medical Providers:* (877) 842-3210 8:00 a.m. to 8:00 p.m. local time, Monday – Friday *For Pharmacists:* (877) 889-6510 24 hours/day, 365 days/year

Houston Onsite Medical Clinic Former Employee

For Information on:	Contact/Address	Phone/Operating Hours
• 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

Retiree Dental

For Information on:	Contact/Address	Phone/Operating Hours
(Applies for retirees eligible for retiree medical insurance and enrolled in a UHC dental option) • Network providers • Covered and non-covered expenses • Claims	UnitedHealthcare Dental Attn: M/S CA 120-0451 P.O. Box 6020 Cypress, CA 90630-0020 **Web:** *www.myuhc.com* **Email:** *SG13001@uhc.com* *Premium payment only:* UnitedHealthcare Dental P.O. Box 887910 Los Angeles, CA 90088-7910	(800) 996-7563 7:00 a.m. to 10:00 p.m. Central time, Monday – Friday *Fax:* (844) 608-0601

Retiree Life and Disability

For Information on:	Contact/Address	Phone/Operating Hours
Life • Claim filing • Coverage questions • Beneficiary designations	Benefits Center P.O. Box 770 Monroe, WI 53566-0770 **Web:** • 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
• Questions after a claim has been paid or denied	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 *Fax:* (866) 954-2621
• 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
Additional information for certain heritage Tosco retirees — *Applies **ONLY** to heritage Tosco retirees affected by the life insurance provisions listed in Appendix II* *"Appendix II," page J-1*	If you are on a waiver of premium due to a disability, there are various life insurance companies insuring the coverage and they will contact you periodically. You will need to keep the insurer's contact information in your records for questions or when a claim is to be reported. If you have a life insurance benefit from a pension plan, you will need to keep the annuity payor's contact information in your records for questions or when a claim is to be reported.	

(continued)

For Information on:	Contact/Address	Phone/Operating Hours
Long-Term Disability • Questions after a claim has been approved (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
Long-Term Disability • Questions after a claim has been approved (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
Additional information for participants disabled prior to Jan. 1, 2003 (or prior to Jan. 1, 2009 if from a Burlington Resources Inc. company)	If your disability benefit payment is not from MetLife, you will need to keep your insurer's contact information in your records for questions and benefit provisions.	

Retiree Medical – Pre-Age 65 Plan

B

Introduction

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

"Glossary," page H-1

In this chapter, the term "Company" is used to describe ConocoPhillips and the other companies whose retirees are covered by this Plan. The term "retiree" is used to describe an eligible participant and does not imply any pension plan eligibility or benefit.

This chapter applies to you **only** if you're:

- An eligible retiree who is **under age 65**;
- An eligible retiree's eligible dependent who is **under age 65**;
- A grandfathered participant-2010; or
- A grandfathered participant-2009.

The ConocoPhillips Retiree Medical Pre-Age 65 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

The following groups **are not** eligible for the retiree medical coverage described in this chapter:

- Heritage Burlington Resources Copper Range retirees
- Heritage Tosco retirees under a Senior Executive Retirement Plan
- Heritage Tosco El Dorado union-represented retirees
- Ineligible Phillips 66 retirees

Retiree Eligibility

You're eligible to participate in the Plan if you're under age 65 and not eligible for Original Medicare **and**:

- You were a U.S. citizen or U.S. resident alien when your employment ended; and:
  - You were an employee paid on the direct U.S. dollar payroll[1] when your employment ended;
  - You are an eligible participant who is not subject to the additional eligibility exclusions described under "Late Enrollment" and in "Appendix I";

    "Late Enrollment," page B-11; "Appendix I," page I-1
  - You met one of the following criteria:
    - You are a terminated ConocoPhillips non-store employee and you meet the 65-point rule[2] for retiree medical eligibility (age plus years of service); or
    - You are a terminated heritage Conoco, heritage Phillips, heritage Tosco individual and you meet the eligibility requirements as outlined in Appendix I; or
    - You are a heritage Burlington Resources Inc. retiree, heritage Burlington Resources Post-1986 Louisiana Land & Exploration (LL&E) retiree, heritage Burlington Resources Pre-1986 Louisiana Land & Exploration (LL&E) retiree or heritage Burlington Resources Pre-1986 El Paso retiree whose employment ended prior to Jan. 1, 2009, and you meet the eligibility requirements as outlined in Appendix I; or
    - You are a grandfathered participant-2009 (includes age 65 and over) or a grandfathered participant-2010 (includes age 65 and over); or

When you or any of your eligible dependents become eligible for Original Medicare due to being age 65 or being under age 65 and disabled (excludes grandfathered participants-2010 or grandfathered participants-2009 and their eligible dependents), the participant will no longer be eligible for this Plan. The participant will only be eligible for the Retiree Medical Age 65 and Over Plan if enrolled in Original Medicare Parts A and B.

"Retiree Medical – Age 65 and Over," page C-1

[1] *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.*

[2] *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.) For more information, refer to the 65-point rule in the Glossary.*

"Glossary," page H-1

- You terminate employment with the Company on or after Jan. 1, 2003, and you meet all of the following criteria:
  - You're approved for long-term disability (LTD) benefits under the ConocoPhillips Long-Term Disability Plan (LTD Plan);
  - Your disability started prior to your termination date;
  - You received approval for LTD benefits within 12 months of your termination date or the end of the elimination period defined by the LTD Plan; and
  - You continue to be eligible for LTD benefits; or

  See "Late Enrollment" and "Appendix I" for additional eligibility provisions.

  "Late Enrollment," page B-11; "Appendix I," page I-1

- You are a surviving spouse/eligible dependent child of an employee eligible for the Employee Medical Plan or a retiree eligible for this Plan. See "What the Plan Costs" for cost sharing provisions. Additional exclusions apply; see "Late Enrollment" and "Appendix I" for information; or

  "Late Enrollment," page B-11; "What the Plan Costs," page B-14; "Appendix I," page I-1

- You are a surviving domestic partner of an employee/retiree who was eligible for this Plan, provided you were enrolled in employee or retiree medical coverage on the date of the employee's/retiree's death. Surviving children of a domestic partner are **not** eligible. See "What the Plan Costs" for cost sharing provisions. Additional exclusions apply; see "Late Enrollment" and "Appendix I" for information.

  "Late Enrollment," page B-11; "What the Plan Costs," page B-14; "Appendix I," page I-1

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

If You Are Rehired/Hired by the Company

Your retiree coverage (as a retiree, as a surviving spouse/domestic partner or as a surviving dependent) will end effective on the date the coverage you elect as an eligible active employee begins. When you subsequently end your employment, you can elect the retiree medical insurance coverage provisions available to you based on your age at the time of re-enrollment. If you are considered an ineligible Phillips 66 retiree when hired by ConocoPhillips and later become eligible for ConocoPhillips retiree benefits, you will no longer be considered an ineligible Phillips 66 retiree.

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 B-7

If you have an eligible dependent (spouse/domestic partner, dependent child) who is also **employed by ConocoPhillips, a pre-age-65 retiree of ConocoPhillips or a grandfathered participant-2010 or a grandfathered participant-2009**, neither you nor any eligible dependent can be covered by more than one Company medical plan, including COBRA. Dual coverage is prohibited even if the other medical coverage is union-sponsored medical coverage.

If both you and your spouse/domestic partner are retired from 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-13

Dependent Eligibility

If an eligible dependent has other medical coverage (in addition to coverage under this Plan) or is eligible for Original Medicare, refer to this Plan's coordination of benefits (COB) provisions.

"If You or a Dependent Becomes Eligible for Medicare," page B-9; "Coordination of Benefits (COB)," page B-50

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 spouse[1]; excluding a spouse after a divorce or separation by a legal separation agreement[2]) 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 26[3]; 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 26[4].

[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 covered under the Phillips 66 retiree medical 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.

In addition, retirees age 65 and over who are eligible for and regardless of whether they enroll or not in the Retiree Medical Age 65 and Over Plan can enroll their eligible dependents who are **under age 65** and not eligible for Original Medicare in this Plan. (Those dependents aren't eligible for the Retiree Medical Age 65 and Over Plan.)

"Retiree Medical – Age 65 and Over," page C-1

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, your coverage may be terminated 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-13

If You or a Dependent Becomes Eligible for Medicare

When you or an eligible dependent becomes eligible for and enroll in Original Medicare Parts A and B due to reaching age 65 or being under age 65 and disabled (excluding grandfathered participants-2010 and grandfathered participants-2009 and their eligible dependents), you or the dependent may become eligible for the Retiree Medical Age 65 and Over Plan.

"Retiree Medical – Age 65 and Over," page C-1

See "Coordination with Medicare" for further information.

"Coordination With Medicare," page B-51

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 Original Medicare coverage due to 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.

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

"Coordination of Benefits (COB)," page B-50

If you or your eligible dependent becomes eligible for Original 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 by calling 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
- Select a payment method for the cost of the coverage you select.

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

HIPAA SPECIAL ENROLLMENT

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). **Note:** These provisions don't apply to enrollments by surviving spouses, surviving domestic partners or surviving dependents.

"In the Event of Your Death," page B-53

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

When to Enroll, Change or Cancel Coverage

You and your eligible dependents can enroll, change or cancel Plan coverage:

- When you become eligible as a new retiree medical participant (see "When Coverage Begins" for time limits);

  "When Coverage Begins," page B-12

- During annual enrollment (see "Late Enrollment" for exclusions); or

  "Late Enrollment," page B-11

- If you have a change in status.

  "Changing or Cancelling Your Coverage," page B-13

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.

Late Enrollment

"Late enrollment" is when an eligible retiree requests enrollment at a time after his or her initial eligibility because he or she did not enroll when first eligible or cancelled coverage after the initial enrollment. If you and your eligible dependents are eligible for late enrollment per chart below, see "When to Enroll, Change or Cancel Coverage" for when you can enroll.

"When to Enroll, Change or Cancel Coverage," page B-10

You'll be required to furnish a document that shows loss of other coverage if you want to enroll for coverage outside the annual enrollment period based on a change in status during the plan year. You will **not** be required to furnish evidence of insurability.

Group	Employment End Date	Late Enrollment Eligibility
Heritage Conoco, heritage Phillips, heritage Tosco, ConocoPhillips retiree	Jan. 1, 2005 and after	Allowed if **eligible** for Company retiree medical coverage on the termination date, unless participation in retiree medical coverage is not allowed based on the terms of your collective bargaining agreement or because you are an ineligible Phillips 66 retiree. *"Retiree Eligibility," page B-5*
Heritage Conoco, heritage Phillips, heritage Tosco, ConocoPhillips retiree	Jan. 1, 2003 through Dec. 31, 2004	Allowed if **enrolled** (as employee, dependent or COBRA participant) in Company employee medical coverage on the termination date (excludes union-sponsored medical coverage).
Heritage Burlington Resources Inc. retiree	Jan. 1, 2007 and after	Allowed if **eligible** for Company employee medical coverage on the termination date or if eligible for retiree medical coverage on or after Jan. 1, 2007, unless participation in retiree medical coverage is not allowed because you are an ineligible Phillips 66 retiree. *"Retiree Eligibility," page B-5*
Heritage Burlington Resources Inc. retiree, heritage Burlington Resources Post-1986 Louisiana Land & Exploration (LL&E) retiree, heritage Burlington Resources Pre-1986 Louisiana Land & Exploration (LL&E) retiree, heritage Burlington Resources Pre-1986 El Paso retiree	Prior to Jan. 1, 2007	Allowed only if **enrolled** in Company retiree medical coverage on Jan. 1, 2007.
Heritage Conoco retiree	Prior to Jan. 1, 2003	Allowed if **enrolled** as of Jan. 1, 2003 or (if not enrolled) allowed if there hasn't been more than one period of non-enrollment between the date became eligible for retiree medical and Jan. 1, 2003.
Heritage Phillips retiree	Prior to Jan. 1, 2003	Allowed
Heritage Tosco retiree	Prior to Jan. 1, 2003	Allowed only if **enrolled** in Company retiree medical coverage on Jan. 1, 2003.
Any heritage company participant eligible due to receipt of long-term disability plan benefits	Refer to provisions of the heritage company and dates above.	Refer to provisions of the heritage company and dates above.
Surviving spouses/domestic partners[1]/dependents of any eligible heritage company retiree	Any dates	Not allowed unless coverage has been continuous (from initial eligibility after the employee's/retiree's death) as the participant in a ConocoPhillips medical plan, including COBRA. Children of a surviving domestic partner are not eligible to enroll.

[1] *A domestic partner can enroll only if covered by a ConocoPhillips medical plan on the date of the retiree's death.*

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:
Newly eligible to participate as a retiree	The later of:[1] • Within 30 calendar days after the event; • Within 30 calendar days of the last day of your employee coverage; or • The date on the enrollment notice form	The later of the date of the event or the first day after employee coverage ends
Newly eligible to participate as a surviving spouse/ domestic partner[2]/dependent	Within 60 calendar days after the end of the month of the employee's/ retiree's death (or by the date on the enrollment notice form, if later); not eligible thereafter	The first of the month following the date of death
Annual enrollment	Within the annual enrollment period	The following Jan. 1
When you have a change in status	See "Changing or Cancelling Your Coverage" for information *"Changing or Cancelling Your Coverage," page B-13*	See "Changing or Cancelling Your Coverage" for information
When you add a new eligible dependent due to birth, adoption or placement for adoption	Within 90 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.*

[2] *A domestic partner can enroll only if covered by a ConocoPhillips medical plan on the date of the retiree's death.*

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-53

Changing or Cancelling 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

If a surviving spouse/domestic partner/dependent cancels his or her retiree medical coverage, he or she will not be eligible to re-enroll in the future unless he or she had continuous coverage under a ConocoPhillips medical plan, excluding a union-sponsored plan. He or she can then re-enroll as a surviving dependent even if eligible for ConocoPhillips retiree medical on his or her own eligibility provisions.

"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* medical 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 and enroll in or lose eligibility for Original Medicare or Medicaid;
- You and/or your eligible dependents become entitled to COBRA; or
- 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 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-8

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 your medical option is eliminated, your coverage will automatically be the HDHP Base option unless you enroll otherwise.

What the Plan Costs

Your cost and the Company's contribution for coverage for yourself and your eligible dependents are based on:

- The Plan option you elect;
- The level of coverage you elect *(You Only, You + One, You + Two or More; costs within these levels vary for Spouse/Domestic Partner + Two or More, You + Child(ren), and Child(ren) Only situations)*;
- Your eligibility date for Plan coverage;
- Whether you're eligible for the 65-point rule (see below); and
- Your heritage company affiliation, if any.

The Benefits Committee reserves the right to recover any underpayments by the participant 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 be provided information about the current cost for each of your available Plan options and levels of coverage.

Retirees and their eligible dependents who choose to enroll in Original Medicare Part D prescription drug coverage can keep their medical coverage under the Plan, but can contact the Benefits Center to have their prescription drug coverage in the Plan cancelled and to qualify for a lower premium for medical-only coverage.

"Contacts," page A-1

Cost-Sharing Based on the 65-Point Rule

Your cost-sharing ratio will be based on the 65-point rule (age plus years of service) if:

- You're a retiree from ConocoPhillips or any heritage company, regardless of your termination date;
- You're considered a ConocoPhillips employee eligible for retiree medical because your employment ended due to approval for Long-Term Disability (LTD) benefits on Jan. 1, 2007 and after. **Note:** Your cost sharing will be the 65-point level (60% of the maximum Company contribution) if you didn't meet the 65-point rule;
- You're an eligible surviving spouse/domestic partner/dependent of any of the above participants. Your cost sharing will be that of the participant. **Note:** Your cost sharing will be the 65-point level (60% of the maximum Company contribution) if the participant did not meet the 65-point rule.

How the 65-Point Rule Works

If you are eligible for this Plan (on your termination date you must be at least age 55 and have a minimum of 10 completed years of service (completed years of service is the difference between your termination date and your company service date), your points are determined on your termination date for eligibility and on Dec. 31 of your termination date year for cost-sharing ratio, regardless of the reason for termination.

Points (Age Plus Years of Service)	Percent of Maximum Company Contribution
85+	100% of maximum Company contribution
80 – 84	90% of maximum Company contribution
75 – 79	80% of maximum Company contribution
70 – 74	70% of maximum Company contribution
65 – 69	60% of maximum Company contribution

COST SHARING & ELIGIBILITY EXAMPLES:

Cathy retired on Feb. 28. On July 25, she will be age 58. She would have completed 14 years of service on Sept. 19.

Age on Feb. 28	57	Age on Dec. 31	58
Service on Feb. 28	13	Service on Dec. 31	14
Points for Eligibility	70	Points for Cost Sharing	72

In this **example**, Cathy is eligible for retiree medical and eligible to receive 70% of the maximum Company contribution.

John retired on Oct. 31. On Dec. 15, he will be age 56. He would have completed 32 years of service on Dec. 20.

Age on Oct. 31	55	Age on Dec. 31	56
Service on Oct. 31	31	Service on Dec. 31	32
Points for Eligibility	86	Points for Cost Sharing	88

In this **example**, John is eligible for retiree medical and eligible to receive 100% of the maximum Company contribution.

Susan retired on June 30. On August 15, she will be age 55. She would have completed 12 years of service on Sept. 23.

Age on June 30	54
Service on June 30	11
Points for Eligibility	65

In this **example**, Susan is **not** eligible for retiree medical because she did not have minimum age requirement of 55 on June 30 (termination date).

Sam retired on July 31. On August 15, he will be age 58. He would have completed 7 years of service on Nov. 1.

Age on July 31	57
Service on July 31	6
Points for Eligibility	63

In this **example**, Sam is **not** eligible for retiree medical because he did not have a minimum of 10 years of completed service on July 31 (termination date).

Company Contributions

The cash flow subsidies for the Retiree Medical Pre-Age 65 Plan and the Retiree Medical Age 65 and Over Plan were combined as of July 1, 2015 to an undiscounted dollar liability cap.

Plan Contributions

Your enrollment authorizes one of the following methods for you to pay the required contributions for Plan coverage for you and your covered dependents:

- Automatic monthly deduction from your savings or checking account; **or**
- Monthly payment to the Benefits Center.

It's your responsibility to make your monthly payment on time. Contributions are due by the first of the month. **A payment due and not made by the first of the current month will result in coverage being cancelled retroactive to the last day of the month in which a payment was received**.

The contribution is the full cost of your (and your dependents') coverage under the Plan, as set by the Company from time to time, based on the option and coverage level that you have elected. This contribution is paid by a combination of contributions made by you and the Company, based on the company contribution information above or in Appendix I. You'll be notified if there is a change in your required contribution. The Company reserves the right to change the contribution associated with various coverage options under the Plan, and its contributions percentage under the cost-sharing ratio at any time.

"Appendix I," page I-1

Retiree Medical Benefit Highlights

The benefits provided by the medical options are discussed in the chart that begins on page B-17. Additional information on medical expenses covered and not covered by the Plan is included beginning on page B-31. Prescription drug benefits are described beginning on page B-42.

"Covered Expenses," page B-31; "Prescription Drug Coverage," page B-42; "Non-Covered Expenses," page B-38

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-30

References in the chart to the *"You Only"* coverage level are for retiree-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).

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

(continued)

[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-27; "Annual Out-of-Pocket Maximum," page B-28

[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] *Includes charges from labs, X-rays, radiologists, 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*
See *hr.conocophillips.com* for the Preventive Care Guide with additional information on the most current covered Preventive Medical Care 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
Walk-In Clinic (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
Physician/Hospital Services	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Second Opinion Office Visit *Second opinions aren't required by the Plan*	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[4]	100% covered after deductible	40% after deductible	100% covered after deductible	40% after deductible
Maternity Care *For births without complications, the Plan provides a minimum 48-hour hospital stay following childbirth (96-hours minimum stay following a cesarean section delivery)* *Hospital or birth center stays beyond 48 hours (or 96 hours) must be medically necessary*	20% after deductible	40% after deductible	20% after deductible	40% after deductible

(continued)

[4] *Includes charges from labs, X-rays, radiologists, 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*
Allergy Testing and Treatment or other injections (such as hormone injections)				
Office Visit (with physician), 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				
Hospital Room and Board *Semiprivate room rate*	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
Pre-Admission Testing	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: Solid organ 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) in excess of a combined maximum of $10,000 per episode of care.[5] Preapproval through the Claims Administrator is required. *"Blue Distinction Centers," page B-31*		You pay travel and lodging expenses (with some limits) in excess of a combined maximum of $10,000 per episode of care.[5] Preapproval through the Claims Administrator is required. *"Blue Distinction Centers," page B-31*	
Travel and lodging expenses for: Complex cardiac, orthopedic and bariatric surgeries from a Blue Distinction Center	You pay travel and lodging expenses (with some limits)in excess of a combined maximum of $10,000 per episode of care.[5] Preapproval through the Claims Administrator is required. Bariatric surgery is covered only if at a Blue Distinction Center. *"Blue Distinction Centers," page B-31*		You pay travel and lodging expenses (with some limits) in excess of a combined maximum of $10,000 per episode of care.[5] Preapproval through the Claims Administrator is required. Bariatric surgery is covered only if at a Blue Distinction Center. *"Blue Distinction Centers," page B-31*	
Emergency Services				
Emergency Room Expenses	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Urgent Care	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Non-Emergency Use of Emergency Room and All Related Expenses	50% after deductible	50% after deductible	50% after deductible	50% after deductible

(continued)

[5] *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*
Mental Health & Substance Use Disorder Treatment				
Inpatient or Outpatient Mental Health/ Substance Use Disorder Treatment	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 *Up to 120 visits per calendar year*	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
Skilled Nursing Facility/Convalescent Nursing Home *Semiprivate room rate. Up to 60 days per calendar year. Custodial care is not covered.*	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-42*		See the chart in "Prescription Drug Coverage" for details. *"Prescription Drug Coverage," page B-42*	

(continued)

Plan Provision	HDHP Option: What You Pay		HDHP Base Option: What You Pay	
	Network	*Non-Network*	*Network*	*Non-Network*
Other				
Ambulance (emergency use only)	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Spinal Manipulation *Must be performed by chiropractor, physical therapist, osteopath; maximum of 20 visits per calendar year*	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Diagnostic Lab and X-rays *Includes complex imaging*[6]	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[7] *Reversal of sterilization is not covered*	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Fertility Treatment[8], including In-Vitro Fertilization and Artificial Insemination	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Acupuncture Therapy *Covered if medically necessary and in lieu of anesthesia*	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Short-term Therapy[9] such as: Occupational Therapy Physical Therapy *Combined maximum of 60 visits per calendar year*[10]	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Services by Houston Onsite Medical Clinic	100% after deductible	N/A	100% after deductible	N/A

[6] *Some services require pre-authorization.*

[7] *Tubal ligations are covered as preventive medical care.*

[8] *Fertility lifetime maximum is $20,000 for medical services and $10,000 for prescription drugs and injections.*

[9] *Is not considered spinal manipulation.*

[10] *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-23

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

  "About the High Deductible Health Plan (HDHP) & HDHP Base Options," page B-23

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-49

The benefits provided by the Plan's medical options are briefly described in this section and in the "Retiree Medical Benefit Highlights" section.

"Retiree Medical Benefit Highlights," page B-16

Additional information on expenses covered and not covered by the Plan is included beginning on page B-31. Prescription drug benefits are described beginning on page B-42.

"Covered Expenses," page B-31; "Non-Covered Expenses," page B-38; "Prescription Drug Coverage," page B-42

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.

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.

"Retiree Medical Benefit Highlights," page B-16; "Annual Deductible," page B-27

Network Providers

When you receive services from a network provider, these 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-27

Once you meet the annual out-of-pocket maximum, these 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-28

✔ 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 benefits for new Plan participants.

"About Network Providers," page B-25

Non-Network Providers

If you receive services from a non-network provider, these 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.

"Retiree Medical Benefit Highlights," page B-16

Once you meet the non-network annual out-of-pocket maximum, these 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-29

The HDHP & 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 coverage[1] (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 but if he/she does not qualify as a dependent on your federal income tax return or if you do not provide at least 50% of their support, then you cannot use your HSA funds for his/her qualified medical expenses.

[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.*

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

- You can make a contribution to an HSA for each year in which you're enrolled in the HDHP or HDHP Base option. The total of your contributions cannot exceed an annual statutory maximum amount set each year by the IRS.
  - 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* or consult your tax or financial advisor.
  - If your spouse also contributes to an HSA, your maximum amount you can contribute to an HSA will be reduced. Consult your tax or financial advisor for information before making your contribution for the year.
- Your after-tax contributions to an HSA 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.
- 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 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 would be advantageous to you and to ensure that you understand all of the tax implications. To learn more about HSAs, see Publication 969 at *www.irs.gov*.

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 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 HSA are provided in these materials.

How the Retiree Medical Plan Works

About Network Providers

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.

"Using Network Providers," below

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. It's your responsibility to remain aware of your provider's network status.

Using Network Providers

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. You can't assume that all of the providers at a network hospital are part of the network or that a specialist you're referred to by a network physician is also part of the network. To avoid being surprised by a lower non-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.

A few exceptions apply:

- If you go to a network hospital and receive services from a non-network radiologist, anesthesiologist or pathologist, those services will be paid at the network benefit level;
- If your network provider refers lab work to a non-network lab without your knowledge, the lab work will be paid as network as long as the non-network lab references your network provider. However, if you choose to use the non-network lab, the services will be paid as non-network;
- Emergency care is paid at the network benefit level, as long as it qualifies as emergency care as determined by the Claims Administrator; and
- If, while you are confined in a network hospital due to illness or injury, you had no opportunity to ensure that all of your service providers were network and those services were paid as non-network, please file an appeal through the appropriate Appeals Administrator.

"Claims Administrators and Appeals Administrators," page G-22

If a Network Provider Is Not Available (Network Deficiency)

NOTE: See page B-45 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 network provider IS available in your network area (meaning there's no network deficiency)	If you choose to use a non-network provider, your claim will be paid at the non-network reimbursement level.
If a network provider is NOT available within 50 miles of your home address (network area)[1] and you want to use a non-network provider	You **must** request approval from the Claims Administrator 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 Claims Administrator. This allows the Claims Administrator to negotiate rates with the provider. If both parties agree, your claim will be paid according to the negotiated rate, 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 Claims Administrator to have your claim adjusted so your cost sharing does not exceed the network reimbursement level. The Claims Administrator will work with you to find the closest appropriate provider for a network deficiency or whether the Travel Assistance benefit is available for specialized care situations that may require additional travel. *"Medical," page B-19* After receiving authorization from the Claims Administrator to use a non-network provider for a network deficiency, the authorization for the network reimbursement level is effective per the timeframe stated on the approval letter from the Claims Administrator. If additional care is required, you must contact the Claims Administrator prior to the expiration of the network deficiency to request an extension. Claims will be paid at the non-network reimbursement level if: • A non-network provider is used and you didn't receive a network deficiency authorization from the Claims Administrator; or • The Claims Administrator did grant authorization, but the authorization has expired.
If you or a covered dependent live outside the network area	You'll need to travel to the nearest network area for care and use a network provider 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. A network deficiency (based on the participant's home address on record at ConocoPhillips) will **not** be granted unless the network area doesn't have the network provider you need.

[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

If you're in an active course of treatment for surgery or a follow-up after surgery, mental health/substance use disorder, transplant, obstetrics or oncology (radiation or chemotherapy) with a non-network provider when your coverage becomes effective, the Claims Administrator may determine that it is appropriate to allow you a transitional period so that your current course of treatment can be completed with the non-network provider. If the Claims Administrator approves transition of care, claims with the approved non-network provider will be paid as network, subject to reasonable and customary limitations. **In order to ensure you receive the highest level of benefits, contact the Claims Administrator and obtain approval prior to continuing your treatment with your current non-network provider.**

"Contacts," page A-1

Some Basic Terms

✔ References to the *"You Only"* coverage level are for retiree-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).

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-17 for annual deductible amounts.

✔ When you retire or become eligible for retiree medical coverage, the amounts that you have spent in the Employee Medical Plan (which apply to your annual deductible, annual or lifetime maximums, etc.) during that calendar year carry over to the Retiree Medical Pre-Age 65 Plan but not to the Retiree Medical Age 65 and Over Plan.

- **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 a retiree changes to a different coverage level *(You Only* or other coverage levels*)* during the calendar year, all expenses applied to the deductible will also be applied to the new coverage-level deductible.

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;
- 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-42
  - 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-30
- 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 enroll in either HDHP option and 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-17 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:** The individual annual out-of-pocket maximum doesn't apply. Instead, the family annual out-of-pocket maximum must be met before the Plan begins paying 100% of most covered expenses for any covered individual. 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 or non-network providers.
- When a retiree changes to a different coverage level *(You Only* or other coverage levels*)* 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;
- 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-42
  - 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-30
- 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).

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 in to 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. (Not available to participants on Medicare.)

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. (Not available to participants on Medicare.)

"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-authorizations 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.

✔ 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.

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

✔ 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.

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 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'll 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 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.

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.

- 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-30
- 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-42
  - 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 retirees;
  - Covered dependent spouses/female domestic partners of retirees; or
  - Covered female dependents of a covered retiree. 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-42 – B-48.

"Prescription Drug Coverage," page B-42

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 retiree dental coverage doesn't apply to charges resulting from an accidental injury.

"Coordination of Benefits (COB)," page B-50

- 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)," at right

- Services from the Houston Onsite Medical Clinic.
- Short-term therapy, as described in the "Retiree Medical Benefit Highlights" section. Contact the Claims Administrator for information regarding types of short-term therapy services and any applicable limits or restrictions.

"Retiree Medical Benefit Highlights," page B-16; "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-31 – B-37, 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-36

- 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:
  - A retiree 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-7
- 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-47

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.

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.
- 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-37

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

[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: Coinsurance 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.

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 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 coinsurance[1] 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-49

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 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 retail 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. 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 physician	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, hospital 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 Claims Administrator 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 Claims Administrator.

[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:*** *Coinsurance 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;
- Antinarcoleptic 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 copayment assistance programs which could lower your out-of-pocket costs for those products. For any such specialty medication where third party copayment 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-40 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-42.

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-42 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-43

Health Improvement Programs

You and your covered dependents (excluding participants with Medicare as primary coverage) are eligible to participate in various health improvement programs at no cost to you. The programs are available on a voluntary basis and cover many complex conditions to lifelong wellness. Contact the Claims Administrator for information on the Well-Being Management programs.

"Contacts," page A-1

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 and Houston Onsite Medical Clinic Former Employee Plan Claims," page G-25

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 G-20

✔ 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 of the year 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)

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

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 plan coordinates 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 Retiree Medical Pre-Age 65 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 a retiree 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 a retiree (or as a retiree's dependent).

  "COBRA Continuation Coverage," page G-10
- 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

Original 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. Original 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 Original Medicare prior to age 65.**

"If You or a Dependent Becomes Eligible for Medicare," page B-9

If you or your dependent becomes entitled to Medicare, Medicare is assumed to be the primary plan.

Note: The Plan reserves the right to implement programs that allow for Original Medicare Part B-eligible prescription drug claims to be filed with Medicare for payment. If you take prescription drugs that can be covered by Original 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.

ABOUT MEDICARE

Original Medicare is the health insurance program sponsored by the federal government for persons age 65 and over (and for certain disabled persons). There are three parts to the coverage:

- **Part A** — Hospital insurance that covers reasonable and medically necessary inpatient hospitalization and some nursing facility expenses. It is financed by separate employee and Company payroll taxes. Normally, the hospital accepts Medicare's payment, and you will not pay additional fees.
- **Part B** — Covers physician and surgeon services, outpatient hospital, home health service, diagnostic tests and other medical benefits. The cost of this part of the Medicare program is paid by you and matched by an equal contribution from federal general funds collected from taxpayers.
- **Part D** — Provides prescription drug coverage.

For detailed information on how Medicare benefits are calculated, contact the Social Security Administration. Remember, **Medicare does not pay benefits outside of the United States**.

EXAMPLE OF COORDINATION OF BENEFITS WITH ORIGINAL MEDICARE

(Not Actual Coverage Amounts)

Cost of Service:	**$85**
1. Medicare-approved amount:	$65
Amount paid by Medicare *(80% of Medicare-approved amount)*:	$52
2. Amount allowed under the Company Plan:	$65
Normal benefits under the Company Plan *(80% of $65)*:	$52
Amount Plan pays after Medicare amount is deducted:	$ 0
3. Amount you pay *($65 allowed amount – $52 paid by Medicare)*	$ 13

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 through COBRA continuation coverage.

"COBRA Continuation Coverage," page G-10

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-53

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

- The last day of the month in which you no longer meet the Plan's eligibility requirements;

  "Retiree 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 before you become eligible for Original Medicare (excludes grandfathered participants-2010 or grandfathered participants-2009 and their eligible dependents);
- The date you're eligible for the Employee Medical Plan, if you're rehired by the Company or if your employment status changes;
- If you're eligible for retiree medical due to qualifying for Long-Term Disability Plan benefits and are not otherwise eligible for retiree medical, coverage for you will end the last day of the month in which your Long-Term Disability Plan benefits end;

  Note: In the event of your death, coverage for your surviving spouse/domestic partner will not terminate due to reaching the date your Long-Term Disability Plan benefits would have ended under the above provision had you not died;
- 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-53
- The date on which the ConocoPhillips Retiree Medical Pre-Age 65 Plan is terminated.

Note: If coverage is terminated or lowered during the month, no reimbursements for any difference in medical coverage level *(You Only* or other coverage levels*)* are made for the month.

If you're in the hospital on the day your coverage ends under the Plan and you're either not covered by another medical plan or your new coverage is the Retiree Medical Age 65 and Over 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 other reason not stated in this section;
- 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 the required cost for dependent coverage isn't paid;
- The last day of the month before your dependent becomes eligible for Original Medicare (excludes grandfathered participants-2010 or grandfathered participants-2009 and their eligible dependents);
- The date your dependent becomes eligible for coverage as a Company employee;
- The date your dependent becomes eligible for the Employee Medical Plan if you're rehired by the Company or if your employment status changes;
- 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; or
- The date of your dependent's death.

In the Event of Your Death

This section does **not** apply to children of a domestic partner, unless specified in Appendix I.

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 G-10; "Appendix I," page I-1

If you were enrolled in the Retiree Medical Pre-Age 65 Plan at the time of your death, medical coverage for your surviving spouse/domestic partner and eligible dependent children who were enrolled 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. If any of your dependents were age 65 and over and enrolled in the Retiree Medical Age 65 and Over Plan, their coverage will continue unless they elect otherwise.

"COBRA Continuation Coverage," page G-10

If your surviving spouse and eligible dependent children **weren't** covered under the Retiree Medical Pre-Age 65 Plan or the Retiree Medical Age 65 and Over Plan on the date of your death, they'll be notified if they are eligible for either of these plans 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 eligible surviving spouse/domestic partner and children can continue to 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 out-of-pocket maximum or lifetime maximum carry over, only upon request to the Claims Administrator, to their new coverage (excluding the Retiree Medical Age 65 and Over Plan).

"Annual Deductible," page B-27; "Annual Out-of-Pocket Maximum," page B-28

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

If your surviving spouse/domestic partner later loses eligibility for medical coverage as an active employee and is not eligible for the retiree coverage, he or she will be eligible to enroll as a surviving spouse/domestic partner if coverage has been continuous in a ConocoPhillips medical plan.

The surviving spouse **cannot** select a mixture of eligibility, cost sharing or other coverage provisions from being both a surviving spouse and an employee/retiree.

Retiree Medical – Age 65 and Over Plan

C

Introduction

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

"Glossary," page H-1

In this chapter, the term "Company" is used to describe ConocoPhillips and the other companies whose retirees are covered by this Plan. The term "retiree" is used to describe an eligible participant and does not imply any pension plan eligibility or benefit.

This chapter applies to you **only** if you're:

- An eligible retiree age 65 and over or an eligible retiree under age 65 eligible for Original Medicare who is a U.S. resident, has a permanent street address in the service area, is enrolled in Original Medicare Parts A and B and is **not** a grandfathered participant-2010 or a grandfathered participant-2009.
- An eligible retiree's dependent age 65 and over or an eligible retiree's dependent under age 65 eligible for Original Medicare who is a U.S. resident, has a permanent street address in the service area, is enrolled in Original Medicare Parts A and B and is **not** a grandfathered participant-2010 or a grandfathered participant-2009.

See the "Retiree Medical – Pre-Age 65" chapter of this handbook if you're a grandfathered participant-2010 or a grandfathered participant-2009.

"Retiree Medical – Pre-Age 65," page B-1

Other eligibility requirements apply. See "Who Is Eligible" for information.

"Who Is Eligible," page C-3

ConocoPhillips Retiree Medical Age 65 and Over Plan (the Plan) provides you and your family with important protection against the financial hardship that often accompanies illness or injury. The Plan is Group Medicare Advantage (PPO) insurance designed to provide health care and prescription coverage for you and your family at a competitive cost.

The Plan described in this chapter offers the UnitedHealthcare® Group Medicare Advantage (PPO) to all eligible participants. Because this Plan includes prescription drug coverage, separate Original Medicare Part D coverage is not allowed. **Note:** If you enroll in another Medicare Advantage Plan or a separate Original Medicare Part D coverage, you will be disenrolled from this Plan. You must be enrolled in Original Medicare Parts A and B and continue paying your Original Medicare Part B premium. The Plan also has extra programs that go beyond the Original Medicare Parts A and B coverage.

Who Is Eligible

The following groups **are not** eligible for the Plan described in this chapter:

- Heritage Burlington Resources Copper Range retirees
- Heritage Tosco retirees under a Senior Executive Retirement Plan
- Heritage Tosco El Dorado union-represented retirees
- Retirees or eligible dependents under age 65 who are not eligible for Original Medicare
- Ineligible Phillips 66 retirees

Retiree Eligibility

You're eligible to participate in the Plan if you're age 65 and over or are under age 65 and eligible for Original Medicare, are a U.S. resident, have a permanent street address in the service area, are enrolled in Original Medicare Parts A and B and are **not** a grandfathered participant-2010 or a grandfathered participant-2009, **and**:

- You were a U.S. citizen or U.S. resident alien when your employment ended, and:
  - You were an employee paid on the direct U.S. dollar payroll[1] when your employment ended;
  - You are an eligible participant who is not subject to the additional eligibility exclusions described under "Late Enrollment" and in "Appendix I"; and

    "Late Enrollment," page C-7; "Appendix I," page I-1
  - You met one of the following criteria:
    - You are a terminated ConocoPhillips non-store employee and you meet the 65-point rule[2] for retiree medical eligibility (age plus years of service); or
    - You are a terminated heritage Conoco, heritage Phillips, heritage Tosco individual and you meet the eligibility requirements as outlined in Appendix I; or
    - You are a heritage Burlington Resources Inc. retiree, heritage Burlington Resources Post-1986 Louisiana Land & Exploration (LL&E) retiree, heritage Burlington Resources Pre-1986 Louisiana Land & Exploration (LL&E) retiree or heritage Burlington Resources Pre-1986 El Paso retiree whose employment ended prior to Jan. 1, 2009, and you meet the eligibility requirements as outlined in Appendix I; or
    - You terminate employment with the Company on or after Jan. 1, 2003, and you meet all of the following criteria:
      - You're approved for long-term disability (LTD) benefits under the ConocoPhillips Long-Term Disability Plan (LTD Plan);
      - Your disability started prior to your termination date;
      - You received approval for LTD benefits within 12 months of your termination date or the end of your elimination period defined by the LTD Plan; and
      - You continue to be eligible for LTD benefits; or

      See "Late Enrollment" and "Appendix I" for additional eligibility provisions.

      "Late Enrollment," page C-7; "Appendix I," page I-1
- You are a surviving spouse/eligible dependent child of an employee eligible for the Employee Medical Plan or a retiree eligible for this Plan. See "What the Plan Costs" for cost sharing provisions. Additional exclusions apply; see "Late Enrollment" and "Appendix I" for information; or

  "Late Enrollment," page C-7; "What the Plan Costs," page C-8; "Appendix I," page I-1
- You are a surviving domestic partner of an employee/retiree who was eligible for this Plan, provided you were enrolled in employee or retiree medical coverage on the date of the employee's/retiree's death. Surviving children of a domestic partner are **not** eligible. See "What the Plan Costs" for cost sharing provisions. Additional exclusions apply; see "Late Enrollment" and "Appendix I" for information.

  "Late Enrollment," page C-7; "What the Plan Costs," page C-8; "Appendix I," page I-1

[1] *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.*

[2] *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.) For more information, refer to 65-point rule in the Glossary.*

"Glossary," page H-1

65-POINT RULE ELIGIBILITY EXAMPLES:

Cathy retired on Feb. 28. On July 25, she will be age 58. She would have completed 14 years of service on Sept. 19.

Age on Feb. 28	57
Service on Feb. 28	13
Points for Eligibility	70

In this **example**, Cathy is eligible for retiree medical because she had 65+ points on Feb 28 (termination date).

Susan retired on June 30. On August 15, she will be age 55. She would have completed 12 years of service on Sept. 23.

Age on June 30	54
Service on June 30	11
Points for Eligibility	65

In this **example**, Susan is **not** eligible for retiree medical because she was not age 55+ on June 30 (termination date).

Sam retired on July 31. On August 15, he will be age 58. He would have completed 7 years of service on Nov. 1.

Age on July 31	57
Service on July 31	6
Points for Eligibility	63

In this **example**, Sam is **not** eligible for retiree medical because he did not have a minimum of 10 years of completed service on July 31 (termination date).

For more information on the 65-point rule, see footnote 2 on page C-3.

If You Are Rehired/Hired by the Company

If you are receiving a Company premium cost-sharing contribution, the contribution as a retiree, as a surviving spouse/domestic partner or as a surviving dependent will end effective on the last day of the month in which you're rehired. When you subsequently end your employment, you can elect the retiree medical insurance coverage provisions available to you based on your age at the time of re-enrollment. You may be eligible for a Company premium cost-sharing contribution until Dec. 31, 2025 if you were covered by the Retiree Medical Age 65 and Over Plan and eligible for a Company contribution on Dec. 31, 2015 and became a rehired retiree on or after Jan. 1, 2016. If you are considered an ineligible Phillips 66 retiree when hired by ConocoPhillips and later become eligible for ConocoPhillips retiree benefits, you will no longer be considered an ineligible Phillips 66 retiree.

If Your Eligible Dependent Is Also a Company Employee or Retiree

Any eligible dependents who are age 65 and over or under age 65 and eligible for Original Medicare cannot be enrolled as a dependent under your coverage. Instead, they can enroll in their own separate policy under the Retiree Medical Age 65 and Over Plan. If you qualify for a Company contribution both as a retiree and as a spouse/domestic partner, you can elect the Company contribution (retiree or spouse/domestic partner) that offers the highest benefit to you. You cannot receive both Company contributions.

Dependent Eligibility

Any of your eligible dependents **age 65 and over** or under age 65 and eligible for Original Medicare who are U.S. residents, have a permanent street address in the service area and who are enrolled in Original Medicare Parts A and B may elect to enroll for coverage. These individuals cannot be enrolled as dependents under your coverage. Instead, they can enroll in their own separate policy under the Retiree Medical Age 65 and Over Plan. They can enroll as long as you are eligible for either the Retiree Medical Age 65 and Over Plan or the Retiree Medical Pre-Age 65 Plan, regardless of whether you are enrolled in the Plan. Eligible dependents include:

- Spouse (including your state-recognized common-law spouse[1]; excluding a spouse after a divorce or separation by a legal separation agreement[2]) 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 65 and over or under age 65 and eligible for Original Medicare, 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 26[3].

[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] *A disabled dependent over age 26 who is disabled prior to age 26 may enroll in the Plan if such disabled dependent experiences a change in status.*

Note: A dependent is **not** eligible for a Company premium cost-sharing contribution if he or she:

- Is under age 65 and not eligible for Original Medicare;
- Is not enrolled in Original Medicare Parts A and B;
- Is not a U.S. resident or has a permanent street address not in the service area;
- Is on active duty in any military service of any country (excluding weekend duty or summer encampments);
- Is not a U.S. citizen or resident alien;
- Is covered under the Phillips 66 retiree medical 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.

In addition, eligible dependents under age 65 and not eligible for Original Medicare are eligible to enroll in the Retiree Medical Pre-Age 65 Plan regardless of whether you enroll or not in the Retiree Medical Age 65 and Over Plan. These dependents aren't eligible for this Retiree Medical Age 65 and Over Plan.

Dependent Certification Rules

When your eligible dependent enrolls for coverage — and for as long as he or she continues that coverage — the dependent is certifying that he or she is an eligible dependent under the terms of the Plan.

If a dependent who doesn't meet the Plan's dependent eligibility requirements enrolls for coverage **or** doesn't cancel coverage within 30 calendar days of when he or she ceases to meet the Plan's dependent eligibility requirements **or** fails to provide required evidence of eligibility, the Plan will consider the actions as evidence of fraud and intentional misrepresentation of a material fact that will trigger rescission that may be back to the date on which the 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. In addition, he or she will be considered an ineligible dependent and may be requested by the Plan to reimburse any Company premium cost-sharing contributions made.

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 for any Company premium cost-sharing contributions in a timely manner may delay the dependent's coverage under the Plan. If coverage is added at a later date, the appropriate documentation of dependent status will be requested again. Contact the Benefits Center for details or if you have any questions about this requirement.

"Contacts," page A-1

If a Dependent Becomes Eligible for Medicare

When an eligible dependent becomes eligible for and enrolls in Original Medicare Parts A and B, only the Retiree Medical Age 65 and Over Plan is available.

If your 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 enroll by contacting the Claims Administrator. 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 Claims Administrator.

"Contacts," page A-1

When you enroll, you'll:

- Choose either the ConocoPhillips Core option or the ConocoPhillips Plus option (If you have Medicare Supplement insurance, you should cancel it because this Plan does not coordinate benefits with other insurance.);
- Decide which of your eligible dependents eligible for Original Medicare will enroll, if any, and if they will enroll in the ConocoPhillips Core option or the ConocoPhillips Plus option (you and your eligible dependents can be enrolled in different options); and
- Select a payment method for the cost of the coverage you select.

✔ Your medical and dental enrollment elections are separate — meaning you can enroll for medical coverage regardless of whether you're enrolled in dental coverage. In the same way, dependents enrolled in medical coverage don't have to be the same as dependents enrolled in dental coverage.

✔ **Medical ID Cards**

The Claims Administrator for medical benefits issues original and replacement ID cards. You will use only your UnitedHealthcare® Group Medicare Advantage (PPO) ID card for all covered medical and prescription drug services. You will not need to use your red, white and blue Original Medicare ID card.

"Contacts," page A-1

✔ When you enroll in this Plan, any expenses that applied to your annual deductible or annual out-of-pocket maximum in the Employee Medical Plan or the Retiree Medical Pre-Age 65 Plan will not transfer to this Plan.

When to Enroll for Coverage

You and your eligible dependents can enroll for medical coverage when you become eligible as a new Plan participant or during annual enrollment. However, some exclusions may apply. See "Late Enrollment," "Changing or Cancelling Your Coverage" and "Appendix I" for details.

"Late Enrollment," below; "Changing or Cancelling Your Coverage," page C-8; "Appendix I," page I-1

Late Enrollment

"Late enrollment" is when an eligible retiree requests enrollment at a time after his or her initial eligibility because he or she did not enroll when first eligible or cancelled coverage after the initial enrollment. If you or your eligible dependents are eligible for late enrollment per the chart below, see "When to Enroll for Coverage" above for when you can enroll.

Group	Employment End Date	Late Enrollment Eligibility
Heritage Conoco, heritage Phillips, heritage Tosco, ConocoPhillips retiree	Jan. 1, 2005 and after	Allowed if **eligible** for Company retiree medical coverage on the termination date, unless participation in retiree medical coverage is not allowed based on the terms of your collective bargaining agreement or because you are an ineligible Phillips 66 retiree. *"Retiree Eligibility," page C-3*
Heritage Conoco, heritage Phillips, heritage Tosco, ConocoPhillips retiree	Jan. 1, 2003 through Dec. 31, 2004	Allowed if **enrolled** (as employee, dependent or COBRA participant) in Company employee medical coverage on the termination date (excludes union-sponsored medical coverage).
Heritage Burlington Resources Inc. retiree	Jan. 1, 2007 and after	Allowed if **eligible** for Company employee medical coverage on the termination date or if eligible for retiree medical coverage on or after Jan. 1, 2007, unless participation in retiree medical coverage is not allowed because you are an ineligible Phillips 66 retiree. *"Retiree Eligibility," page C-3*
Heritage Burlington Resources Inc. retiree, heritage Burlington Resources Post-1986 Louisiana Land & Exploration (LL&E) retiree, heritage Burlington Resources Pre-1986 Louisiana Land & Exploration (LL&E) retiree, heritage Burlington Resources Pre-1986 El Paso retiree	Prior to Jan. 1, 2007	Allowed only if **enrolled** in Company retiree medical coverage on Jan. 1, 2007.
Heritage Conoco retiree	Prior to Jan. 1, 2003	Allowed if **enrolled** as of Jan. 1, 2003 or (if not enrolled) allowed if there hasn't been more than one period of non-enrollment between the date became eligible for retiree medical and Jan. 1, 2003.
Heritage Phillips retiree	Prior to Jan. 1, 2003	Allowed
Heritage Tosco retiree	Prior to Jan. 1, 2003	Allowed only if **enrolled** in Company retiree medical coverage on Jan. 1, 2003.
Any heritage company participant eligible due to receipt of long-term disability plan benefits	Refer to provisions of the heritage company and dates above.	Refer to provisions of the heritage company and dates above.
Surviving spouses/domestic partners[1]/ dependents of any eligible heritage company retiree	Any dates	Not allowed unless coverage has been continuous, from initial eligibility after the retiree's/employee's death, as a participant in a ConocoPhillips medical plan, including COBRA. Children of a surviving domestic partner are not eligible to enroll.

[1] *A domestic partner can enroll only if covered by a ConocoPhillips medical plan on the date of the retiree's death.*

When Coverage Begins

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

For the following event:	If an enrollment action is made with the Claims Administrator:	The coverage change effective date is:
Newly eligible to participate	The later of: • Within 30 calendar days after the event; • Within 30 calendar days of the last day of your employee coverage	First of the month following enrollment action but no earlier than Original Medicare Part B effective date.
Newly eligible to participate as a surviving spouse/domestic partner[1]/dependent who is age 65 and over or under age 65 and eligible for Original Medicare	Within 60 calendar days after the end of the month of the employee's/retiree's death; not eligible thereafter	First of the month following enrollment action but no earlier than Original Medicare Part B effective date.
Annual enrollment	Within the annual enrollment period set by the Company	The following Jan. 1
When you have a change in status eligible for Medicare's Special Enrollment Period	See "Changing or Cancelling Your Coverage" below for information.	

[1] *A domestic partner can enroll only if covered by a ConocoPhillips medical plan on the date of the retiree's death.*

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 C-12

Changing or Cancelling Your Coverage

You can change from one coverage option to another or cancel coverage during each year's annual enrollment set by the Company. To cancel or change coverage options outside the annual enrollment period, contact the Claims Administrator and they will provide further information on when the coverage change can become effective.

"Contacts," page A-1

If you decide to change your insurance from this UnitedHealthcare® Group Medicare Advantage (PPO) to a Medicare Supplement insurance plan, please contact the Claims Administrator prior to making a change to confirm eligibility, plan and premium provisions.

"Contacts," page A-1

What the Plan Costs

You pay 100% of your premium for your combined medical coverage and prescription drug coverage. When you enroll or change options, your cost for coverage for yourself and your eligible dependents is based on which option you elect, whether you are subject to any Medicare Late Enrollment Penalty (LEP), whether you are eligible for assistance on prescription drug premium and cost sharing costs by a Medicare Low Income Premiums Subsidy (LIPS), your state of residence, your age and your Original Medicare Part B effective date. You can contact the Claims Administrator for your premium amount on the two options or you'll receive that information when you enroll. **In addition, you will need to pay your separate Original Medicare Part B premium.**

Participants (includes retirees and their eligible dependents) who have Plan coverage on Dec. 31, 2015 will continue to be eligible to receive Company premium cost-sharing contributions (also known as "Company subsidy") until no later than Dec. 31, 2025, per the provisions in effect on Dec. 31, 2015; however, premium cost-sharing contributions will be phased out over a ten-year period with the contributions ending on or before Dec. 31, 2025. This includes a participant who was a ConocoPhillips employee eligible for retiree medical because his or her employment ended due to approval for long-term disability (LTD) benefits on Jan. 1, 2007 or after, and an eligible surviving spouse/domestic partner or dependent of any participant. New participants in the Retiree Medical Age 65 and Over Plan on Jan. 1, 2016 and after pay 100% of the Plan premium.

Effective Jan. 1, 2021, if you voluntarily terminate your Plan coverage for any reason other than being rehired by the Company, the Company premium cost-sharing contribution will not be reinstated. If coverage for you or your eligible dependent(s) for this Plan is terminated due to non-payment, the Company premium cost-sharing contribution will only be reinstated if you pay all back premiums subject to the Claims Administrator's procedures. Effective Jan. 1, 2019, the premium cost-sharing contribution was reinstated one time only if you had become subject to a premium cost share for the first time as a result of the contribution phase out. Effective Jan. 1, 2016, the contribution was not reinstated for any reason other than being rehired by the Company. A rehired retiree and any eligible dependents (who were eligible for the Company premium cost-sharing contribution and covered by the Plan on Dec. 31, 2015) may subsequently re-enroll in the Plan after termination of employment and receive the Company premium cost-sharing contribution, if still available. If the Company contribution is terminated for only the retiree/surviving dependent/long-term disability participant, it can be continued for any of the participant's eligible dependents, as long as their individual coverage is not terminated.

The cash flow subsidies for the Retiree Medical Pre-Age 65 and Retiree Medical Age 65 and Over component plans were combined as of July 1, 2015 and to an undiscounted dollar liability cap.

"Appendix I," I-4

Your enrollment authorizes one of the following methods for you to pay the required contributions for Plan coverage for you and your covered dependents:

- Automatic monthly deduction from your savings or checking account; **or**
- Monthly or lump sum payments by check or credit card to the Claims Administrator.

It's your responsibility to make your monthly payment on time. Contributions are due by the 1st of the month for that month's coverage.

Retiree Medical Benefit Highlights

See the "Retiree Medical – Pre-Age 65" chapter of this handbook if you're under age 65 and not eligible for Original Medicare or not eligible for Original Medicare or you're a grandfathered participant-2010 or a grandfathered participant-2009.

"Retiree Medical – Pre-Age 65," page B-1

About the Retiree Medical Age 65 and Over Plan

The Retiree Medical Age 65 and Over Plan is offered by the Company for participants age 65 and over or an eligible retiree under age 65 and eligible for Original Medicare who are U.S. residents, have a permanent street address in the service area, and are enrolled in Original Medicare Parts A and B. The Plan offers either the ConocoPhillips Core option or the ConocoPhillips Plus option. You can see any network provider or non-network provider and you pay the same coinsurance and/or copay, as long as the provider accepts UnitedHealthcare® Group Medicare Advantage (PPO) and Original Medicare.

The Retiree Medical Age 65 and Over Plan includes prescription drug coverage. Separate Original Medicare Part D prescription drug coverage is not allowed and you will be disenrolled in this Plan. Enrollment in an additional Medicare Supplement insurance or another Medicare Advantage Plan is also not allowed. There are many other additional tools and programs available to support your health that are not part of the Original Medicare coverage. In the first 90 days after your coverage effective date, you'll receive a call that Medicare requires from the Claims Administrator to ask you to complete a short health survey by phone or online. Below is a summary of basic Plan details:

Medical	ConocoPhillips Core (In-Network or Non-Network)	ConocoPhillips Plus (In-Network or Non-Network)
Annual Deductible	$0	$0
Annual Out-of-Pocket Maximum	$2,800	$500
Office Visit Copay	$15 (primary) $30 (specialist)	$5 (primary) $10 (specialist)
Hospital Inpatient Copay	$250 per admission	$50 per admission
ER Copay	$100	$75
Urgent Care Copay	$35	$10
Prescription Drug	**(In-Network)**	
Annual Deductible	$250	$250
Generic Copay	$5, after annual deductible	$5, after annual deductible
Preferred Brand Copay	$45, after annual deductible	$45, after annual deductible
Non-Preferred Brand	40% coinsurance, after annual deductible	40% coinsurance, after annual deductible
Specialty	30% coinsurance, after annual deductible	30% coinsurance, after annual deductible
Mail Order • Preferred Generic / Preferred Brand • Non-Preferred / Specialty Tier	 $15 / $135 copay, after annual deductible 40% / 30% coinsurance, after annual deductible	 $15 / $135 copay, after annual deductible 40% / 30% coinsurance, after annual deductible
• True Out-of-Pocket (TrOOP)[1]	$2,000	$2,000

[1] *Effective Jan. 1, 2025 you will have the option to pay your True Out-of-Pocket (TrOOP) prescription drug costs in monthly installments over the remainder of the calendar year under the Medicare Prescription Payment Plan (M3P). You pay $0 up front, the plan pays the pharmacy for your cost share and then bills you monthly for your cost share. Contact the Claims Administrator for information or to enroll In the M3P any time during the calendar year.*

"Contacts," page A-1

Your enrollment materials will include detailed information on the UnitedHealthcare® Group Medicare Advantage (PPO) options available and are not described in this SPD. If you elect to enroll in the Plan, the Claims Administrator will provide you a separate Evidence of Coverage. The Evidence of Coverage and this SPD, when combined, constitute your Summary Plan Description. Sections of this SPD handbook that do not apply to the Plan will be indicated.

✔ Because the Claims Administrator pays all claims directly, the claims do not go to Original Medicare first.

Before you enroll in the Retiree Medical Age 65 and Over Plan ...

You may make a written request to the Claims Administrator to obtain a Plan Guide and Summary of Benefits prior to enrollment explaining:

- The benefits and services provided to participants;
- Eligibility to receive such benefits and when benefits may be denied;
- How to obtain benefits; and
- The timing requirements for bringing different types of claims and appeals.

Any questions regarding benefits should be referred to the Claims Administrator.

"Contacts," page A-1

ABOUT ORIGINAL MEDICARE

Original Medicare is the health insurance program sponsored by the federal government for persons age 65 and over (and for certain disabled persons). There are three parts to the coverage:

- **Part A** — Hospital insurance that covers reasonable and medically necessary inpatient hospitalization and some nursing facility expenses. It is financed by separate employee and Company payroll taxes. Normally, the hospital accepts Original Medicare's payment, and you will not pay additional fees, other than any applicable deductible.
- **Part B** — Covers physician and surgeon services, outpatient hospital, home health service, diagnostic tests and other medical benefits. The cost of this part of the Original Medicare program is paid by you and matched by an equal contribution from federal general funds collected from taxpayers.
- **Part D** — Provides prescription drug benefits.

For detailed information on how Original Medicare benefits are calculated, contact the Social Security Administration. Remember, **Original Medicare does not pay benefits outside of the United States**.

When Coverage Ends

In the event you're no longer eligible for a Company contribution toward your coverage, you will be able to continue the same coverage without any Company contribution.

"In the Event of Your Death," page C-12

Your eligibility for a Company premium cost-sharing contribution will end on the earliest of the following events:

- The last day of the month in which you no longer meet the Plan's eligibility requirements for a contribution;

  "Retiree Eligibility," page C-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 you're eligible for the Employee Medical Plan, if you're rehired by the Company or if your employment status changes;
- The last day of the month in which your Long-Term Disability Plan benefits end if you're eligible for retiree medical due to qualifying for Long-Term Disability Plan benefits and are not otherwise eligible for retiree medical.

  Note: In the event of your death, the Company contribution for your surviving spouse/domestic partner will not terminate due to reaching the date your Long-Term Disability Plan benefits would have ended under the above provision had you not died;
- 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 C-12
- The date on which the ConocoPhillips Retiree Medical Age 65 and Over Plan is terminated.

Note: If coverage is terminated during the month, premiums are not prorated and no reimbursements are made for the month.

Eligibility for a Company premium cost-sharing contribution 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 other reason not stated in this section;
- 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 the required cost for dependent coverage isn't paid;
- The last day of the month in which your dependent becomes eligible for coverage as a Company employee;
- The last day of the month in which your dependent becomes eligible for the Employee Medical Plan, if you're rehired by the Company; or
- The date of your dependent's death.

In the Event of Your Death

This section does **not** apply to children of a domestic partner, unless specified in Appendix I.

A surviving dependent under age 65 and not eligible for Original Medicare 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 G-10; "Appendix I," page I-1

If your surviving spouse/domestic partner and/or eligible dependent children (excluding children of a domestic partner) were enrolled in the Retiree Medical Age 65 and Over Plan on the date of your death, their coverage will continue unless they elect otherwise. If they are under age 65 and enrolled in the Retiree Medical Pre-Age 65 Plan, their coverage will continue until the last day of the month in which your death occurred, and then they may be eligible to continue coverage through COBRA or through the ConocoPhillips Retiree Medical Pre-Age 65 Plan.

If your surviving spouse and eligible dependent children **weren't** covered under the Retiree Medical Pre-Age 65 Plan or under the Retiree Medical Age 65 and Over Plan on the date of your death, they'll be notified if they are eligible for either of these plans 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 can enroll in retiree medical coverage regardless of whether your surviving spouse also enrolls.

Retiree medical coverage for your eligible surviving spouse/domestic partner and children can continue to be the same coverage that you would have been eligible for as a retiree or long-term disability participant.

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

"Who Is Eligible," page C-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 is continuous.

If your surviving spouse/domestic partner later loses eligibility for medical coverage as an active employee and is not eligible for the retiree coverage, he or she will be eligible to enroll as a surviving spouse/domestic partner if coverage has been continuous in a ConocoPhillips medical plan.

The surviving spouse **cannot** select a mixture of eligibility, cost sharing or other coverage provisions from being both a surviving spouse and an employee/retiree.

Houston Onsite Medical Clinic Former Employee Plan

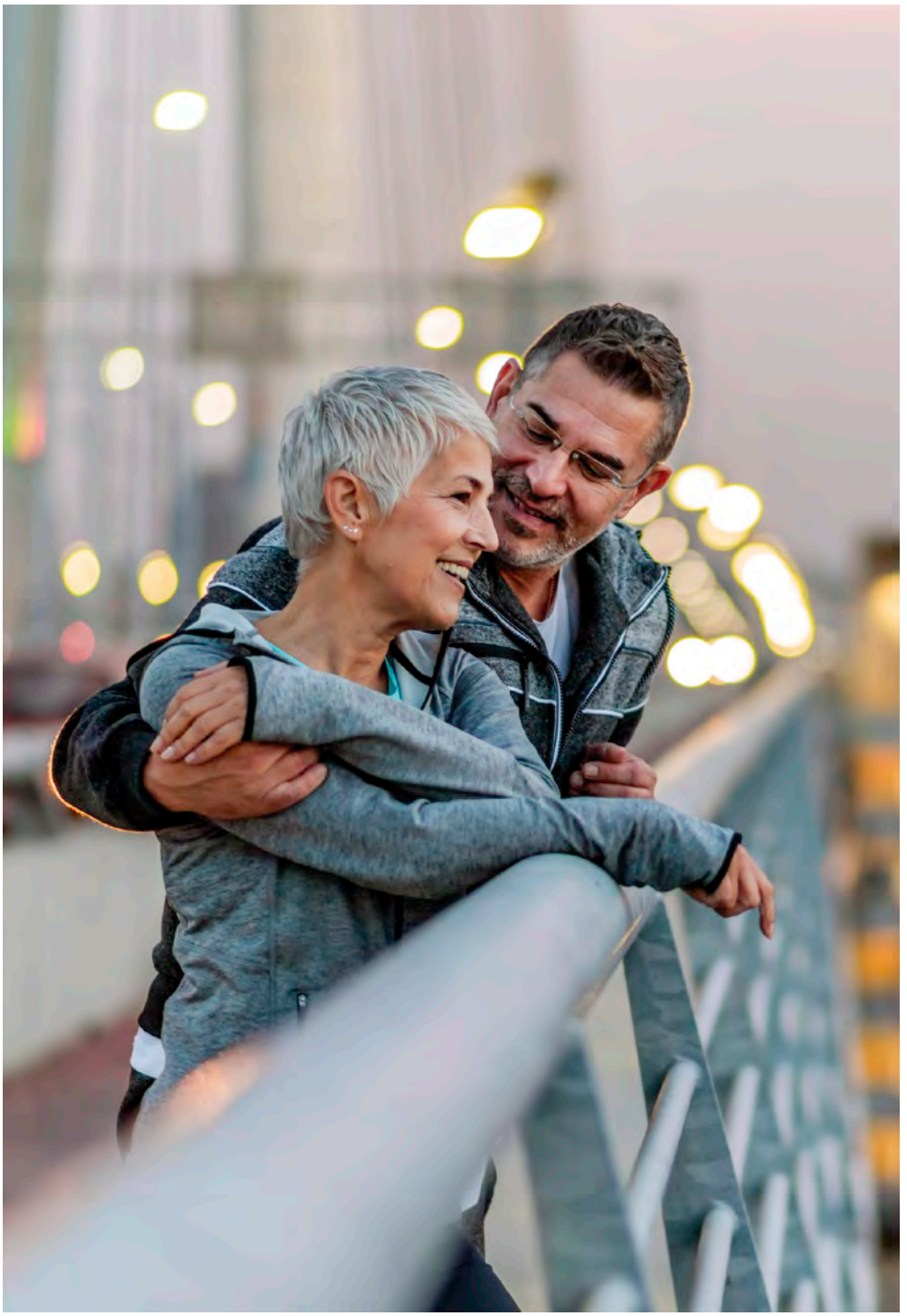
D

Introduction

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

"Glossary," page H-1

The ConocoPhillips Houston Onsite Medical Clinic Former Employee Plan (the Plan) provides you and your family access to a full-service primary care clinic with services at fixed rates. The onsite clinic provides a convenient and affordable option for medical care. The Plan has been designed to provide certain medical services for you and your family at a competitive cost.



Who Is Eligible

✔ Ineligible Phillips 66 retirees are not eligible for this Plan.

Former Employee Eligibility

You're eligible to participate in the Plan if you were a ConocoPhillips non-store employee Jan. 1, 2003 and after, a U.S. citizen or U.S. resident alien and were paid on the direct U.S. dollar payroll[1] when you terminated employment or if you are a surviving spouse/domestic partner/eligible dependent of such terminated employee.

Dependent Eligibility

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

- Spouse (including your state-recognized common-law spouse[2]; excluding a spouse after a divorce or separation by a legal separation agreement[3]) 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 26[4]; 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 26[5].

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.

[1] *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.*

[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 change in status.*

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, your coverage may be terminated 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

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.

"Former 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.

Houston Onsite Medical Clinic Former Employee 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

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 the Houston Onsite Medical Clinic Former Employee Plan Works

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

- If you are covered by the ConocoPhillips Retiree Medical Pre-Age 65 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 Retiree Medical Pre-Age 65 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 Retiree Medical Pre-Age 65 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.

"Retiree Medical Pre-Age 65," Page B-1

How to File a Claim

If you are enrolled in the Retiree Medical Pre-Age 65 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 Retiree Medical Pre-Age 65 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 Former Employee 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 G-20

When Coverage Ends

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

- The last day of the month in which you no longer meet the Plan's eligibility requirements;

  "Former Employee Eligibility," page D-3
- The date you're eligible for the Houston Onsite Medical Clinic Plan, if you're rehired by the Company;
- The date of your death (see "In the Event of Your Death" for information about continued coverage for your surviving dependents); or

  "In the Event of Your Death," page D-6
- The date on which the ConocoPhillips Houston Onsite Medical Clinic Former Employee Plan is terminated.

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

- The date your dependent becomes eligible for coverage as a Company employee;
- The date your dependent becomes eligible for the Houston Onsite Medical Clinic Plan if you're rehired by the Company or if your employment status changes;
- 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; or
- The date of your dependent's death.

In the Event of Your Death

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

Retiree Dental Plan

E

Introduction

The Retiree Dental 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 H-1 for the definitions of underlined terms used throughout this SPD.

"Glossary," page H-1

In this chapter, the term "Company" is used to describe ConocoPhillips and the other companies whose retirees are covered by this Plan. The term "retiree" is used to describe an eligible participant and does not imply any pension plan eligibility or benefit.

Who Is Eligible

The following groups **are not** eligible for the retiree dental coverage described in this chapter:

- Heritage Burlington Resources Copper Range retirees
- Heritage Tosco retirees under a Senior Executive Retirement Plan
- Heritage Tosco El Dorado union-represented retirees
- Ineligible Phillips 66 retirees

Retiree Eligibility

You're eligible to participate in the Plan if:

- You were a U.S. citizen or U.S. resident alien when your employment ended, and:
  - You were an employee paid on the direct U.S. dollar payroll[1] when your employment ended;
  - You are an eligible participant who is not subject to the additional eligibility exclusions described under "Late Enrollment" and in "Appendix I"; and

    "Late Enrollment," page E-7; "Appendix I," page I-1
  - You met one of the following criteria:
    - You are a terminated ConocoPhillips non-store employee and you meet the 65-point rule[2] for retiree medical eligibility (age plus years of service); or
    - You are a terminated heritage Conoco, heritage Phillips, heritage Tosco individual and you meet the eligibility requirements as outlined in Appendix I; or
    - You are a heritage Burlington Resources Inc. retiree, heritage Burlington Resources Post-1986 Louisiana Land & Exploration (LL&E) retiree, heritage Burlington Resources Pre-1986 Louisiana Land & Exploration (LL&E) retiree, or heritage Burlington Resources Pre-1986 El Paso retiree and you meet the eligibility requirements as outlined in Appendix I; or
    - You are a grandfathered participant-2009 (includes age 65 and over); or
    - You terminate employment with the Company on or after Jan. 1, 2003, and you meet all of the following criteria:
      - You're approved for long-term disability (LTD) benefits under the ConocoPhillips Long-Term Disability Plan (LTD Plan);
      - Your disability started prior to your termination date;
      - You received approval for LTD benefits within 12 months of your termination date or the end of the elimination period defined by the LTD Plan; and
      - You continue to be eligible for LTD benefits; or

      See "Late Enrollment" and "Appendix I" for additional eligibility provisions.

      "Late Enrollment," page E-7; "Appendix I," page I-1

[1] *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.*

[2] *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). For more information, refer to the 65-point rule in the Glossary.*

"Glossary," page H-1

- You are a surviving spouse/eligible dependent child of an employee eligible for the Employee Dental Plan or a retiree eligible for this Plan. Additional exclusions apply; see "Late Enrollment" and "Appendix I" for information; or

  "Late Enrollment," page E-7; "Appendix I," page I-1

- You are a surviving domestic partner of an employee/retiree who was eligible for this Plan, provided you were enrolled in employee or retiree dental coverage on the date of the employee's/retiree's death. Surviving children of a domestic partner are **not** eligible. Additional exclusions apply; see "Late Enrollment" and "Appendix I" for information.

  "Late Enrollment," page E-7; "Appendix I," page I-1

If You Are Rehired/Hired by the Company

Your retiree coverage (as a retiree or a surviving spouse/domestic partner or surviving dependent) will continue unless you elect to cancel it when the coverage you elect as an eligible active employee begins. When you subsequently end your employment, you can elect the retiree dental insurance coverage provisions available to you at the time of re-enrollment. If you are considered an ineligible Phillips 66 retiree when hired by ConocoPhillips and later become eligible for ConocoPhillips retiree benefits, you will no longer be considered an ineligible Phillips 66 retiree.

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-5

If you have an eligible dependent (spouse/domestic partner, dependent child) who is also **employed by or retired from ConocoPhillips**, any eligible dependent can be covered by more than one Company dental option or COBRA. However, coordination of benefit provisions may apply. If both you and your spouse/domestic partner are retired from ConocoPhillips, your election is considered to be a separate election from your spouse's/domestic partner's election. Coverage can be changed anytime during the calendar year.

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.

If you enroll in the Plan, your eligible dependents[1] may also be enrolled for coverage. Eligible dependents include your:

- Spouse (including your state-recognized common-law spouse[2]; excluding a spouse after a divorce or separation by a legal separation agreement[3]) 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 26[4]; 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 26[5].

[1] *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 enroll in the Plan if such disabled dependent experiences a 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 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.

Note: Your eligible dependents cannot be enrolled as a dependent under your coverage. Instead, they can enroll in their own separate policy under the Retiree Dental option. If the coverage is terminated retroactively, the Plan will give the participant a 30-calendar-day notice.

How to Enroll, Change or Cancel Coverage

If you or your eligible dependents want to enroll in dental coverage, contact the Claims Administrator for enrollment instructions. 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 Claims Administrator.

"Contacts," page A-1

When you enroll, you'll:

- Choose from the Plan options available to you; and
- Select a payment method for the cost of the coverage you select.

Your medical and dental enrollment elections are separate — meaning you can enroll for dental coverage regardless of whether you're enrolled in medical coverage, and vice versa. In the same way, eligible dependents enrolled in medical coverage don't have to be the same as dependents enrolled in dental coverage.

Note: The Claims Administrator issues original and replacement ID cards to plan participants.

When to Enroll, Change or Cancel Coverage

You and your eligible dependents can enroll, change or cancel dental coverage anytime after you become eligible as a new Plan participant. However, some exclusions may apply. See "Late Enrollment" and "Appendix I" for details.

"Late Enrollment," page E-7; "Appendix I," page I-1

Late Enrollment

Late enrollment is when an eligible retiree requests enrollment at a time after their initial eligibility because he or she did not enroll when first eligible or cancelled coverage after initial enrollment. If you and your eligible dependents are eligible for late enrollment per chart below , see "When to Enroll, Change or Cancel Coverage" for when you can enroll.

"When to Enroll, Change or Cancel Coverage," page E-6

Group	Employment End Date	Late Enrollment Eligibility
Heritage Conoco, heritage Phillips, heritage Tosco, ConocoPhillips retiree	Jan. 1, 2005 and after	Allowed if **eligible** for Company retiree medical coverage on the termination date, unless participation in retiree medical coverage is not allowed based on the terms of your collective bargaining agreement.
Heritage Conoco, heritage Phillips, heritage Tosco, ConocoPhillips retiree	Jan. 1, 2003 through Dec. 31, 2004	Allowed if **enrolled** (as employee, dependent or COBRA participant) in Company employee medical coverage on the termination date (excludes union-sponsored medical coverage).
Heritage Burlington Resources Inc. retiree	Jan. 1, 2007 and after	Allowed if **eligible** for Company employee medical coverage on termination date or if eligible for retiree medical coverage on or after Jan. 1, 2007.
Heritage Burlington Resources Inc. retiree, heritage Burlington Resources Post-1986 Louisiana Land & Exploration (LL&E) retiree, heritage Burlington Resources Pre-1986 Louisiana Land & Exploration (LL&E) retiree, heritage Burlington Resources Pre-1986 El Paso retiree	Prior to Jan. 1, 2007	Allowed only if **enrolled** in Company retiree medical coverage on Jan. 1, 2007.
Heritage Conoco retiree	Prior to Jan. 1, 2003	Allowed if **enrolled** as of Jan. 1, 2003 or (if not enrolled) allowed if there hasn't been more than one period of non-enrollment between the date became eligible for retiree medical and Jan. 1, 2003.
Heritage Phillips retiree	Prior to Jan. 1, 2003	Allowed
Heritage Tosco retiree	Prior to Jan. 1, 2003	Allowed only if **enrolled** in Company retiree medical coverage on Jan. 1, 2003.
Any heritage company participant eligible due to receipt of long-term disability plan benefits	Refer to provisions of the heritage company and dates above.	Refer to provisions of the heritage company and dates above.
Surviving spouses/domestic partners[1]/ dependents of any eligible heritage company retiree	Any dates	Allowed. However, children of a surviving domestic partner are not eligible to enroll.

[1] *A domestic partner can enroll only if covered by a ConocoPhillips dental option on the date of the retiree's death.*

When Coverage Begins

If the enrollment form is received by the 20th of the month, coverage will begin the first of the month following receipt of the form. If the enrollment form is received **after** the 20th of the month, coverage will begin the first of the second following month. (For example, if the enrollment form is received on Dec. 20, coverage will begin the following Jan. 1. If the form is received Dec. 21, coverage will begin the following Feb. 1.)

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-9

Changing Your Coverage

To make changes, contact the Claims Administrator. You can make changes anytime during the calendar year.

"Contacts," page A-1

What the Plan Costs

You and your enrolled dependents each pay the full cost for dental coverage under the Plan.

When you enroll, you'll be provided information about the current cost for each of your available options.

Retiree Dental Benefit Highlights

You can use a network or a non-network dentist. When you enroll, you choose which option you want based on deductible, annual maximum and coverage provisions. Four options are available:

- Higher annual plan maximum with dental implants;
- Higher annual plan maximum without dental implants;
- Lower annual plan maximum with dental implants; and
- Lower annual plan maximum without dental implants.

The benefits provided under Retiree Dental aren't described in this SPD. If you elect Retiree Dental, the Claims Administrator will provide you a separate Certificate of Coverage. The Certificate of Coverage and this SPD, when combined, constitute your Summary Plan Description. Sections of this SPD handbook that do not apply to this Plan will be indicated.

Before you enroll in Retiree Dental ...

Be sure to read the Retiree Dental Certificate of Coverage to learn about the benefits provided. By making a written request to the Claims Administrator, you may obtain materials prior to enrollment explaining:

- The services provided to participants;
- Eligibility to receive such services and when services may be denied;
- How to obtain services; and
- How to appeal a denied benefit claim.

Any questions regarding benefits should be referred to the Claims Administrator.

"Contacts," page A-1

When Coverage Ends

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 E-9

Coverage for you or your eligible dependents will end on the earliest of the following events:

- The last day of the month in which you or your dependents don't pay the required cost for coverage;
- The last day of the month in which you or your dependents no longer meet the Plan's eligibility requirements;
- The date of the covered person's death; or
- The date on which the ConocoPhillips Retiree Dental Plan is terminated.

In the Event of Your Death

This section does **not** apply to children of a domestic partner, unless specified in Appendix I.

"Appendix I," page I-1

If your surviving spouse/domestic partner and/or eligible dependent children (excluding children of a domestic partner) were enrolled in a retiree dental option on the date of your death, their coverage will continue unless they elect otherwise.

If your surviving spouse and eligible dependent children **weren't** covered under a Company dental option 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 can enroll in a retiree dental option regardless of whether your surviving spouse also enrolls.

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

If your surviving spouse/domestic partner later loses eligibility for dental coverage as an active employee and is not eligible for retiree coverage, he or she will be eligible to enroll as a surviving spouse/domestic partner.

The surviving spouse **cannot** select a mixture of eligibility, cost sharing or other coverage provisions from being both a surviving spouse and an employee/retiree.

Retiree Life Plan

F

Introduction

The ConocoPhillips Group Retiree Life Plan (the Plan or the Retiree Life Plan) provides an opportunity for you to purchase life coverage for yourself. This coverage can provide your family with valuable financial protection in the event of your death.

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

"Glossary," page H-1

In this chapter, the term "Company" refers to ConocoPhillips and the other companies that have adopted this Plan. The term "retiree" is used to describe an eligible participant and does not imply any pension plan eligibility or benefit.

Who Is Eligible

The following groups **are not** eligible for the Retiree Life Plan:

- Heritage Burlington Resources Pre-1986 Louisiana Land & Exploration retirees
- Heritage Burlington Resources Copper Range retirees
- Heritage Tosco retirees under a Senior Executive Retirement Plan
- Heritage Tosco El Dorado union-represented retirees

"Appendix II," page J-1

Retiree Eligibility

You are eligible to participate in the Plan if you are **under age 65 and**:

- You were a U.S. citizen or U.S. resident alien when your employment ended, and you meet all of the following conditions:
  - You were an employee paid on the direct U.S. dollar payroll[1] when your employment ended;
  - You meet the 65-point rule[2] for eligibility (age plus years of service);
  - You were an employee participating in the Basic or Supplemental Life options under the ConocoPhillips Group Life Plan on your termination date; and
  - Your Company employment ended on or after Jan. 1, 2003;
- You are a grandfathered participant-2009;
- You are a heritage Burlington Resources Inc. retiree, heritage Burlington Resources Post-1986 Louisiana Land & Exploration (LL&E) retiree or heritage Burlington Resources Pre-1986 El Paso retiree whose employment ended prior to Jan. 1, 2009, and you meet the eligibility requirements as outlined in Appendix II; or
- You are a terminated heritage Conoco or heritage Phillips or heritage Tosco employee whose employment ended prior to Jan. 1, 2003, and you meet the eligibility requirements as outlined in Appendix II.

"Appendix II," page J-1

If your employment ended before Jan. 1, 2003, see Appendix II for different retiree life coverage provisions that may apply to you.

"Appendix II," page J-1

[1] *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.*

[2] *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). For more information, refer to the 65-point rule in the Glossary.*

"Glossary," page H-1

If You Are Rehired/Hired by the Company

Your retiree coverage will end effective on the date your coverage as an eligible active employee begins. When you subsequently end your employment and if your age is eligible you can elect the retiree life coverage level available to you at the time of re-enrollment.

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," below

If Your Eligible Spouse Is Also a Company Employee or Retiree

If both you and your eligible dependent spouse work or have worked for ConocoPhillips, you can be enrolled for coverage both as a retiree and as a spouse of an active employee. Retiree coverage does not include dependent life coverage for a spouse.

How to Enroll, Change or Cancel Coverage

If you want to enroll in, decrease or cancel life coverage for yourself, 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 coverage amounts available to you; and
- Select a payment method for the coverage you select.

If you do not enroll in the Retiree Life Plan when initially eligible, you cannot enroll in it in the future. If you cancel or decrease coverage, you cannot later re-enroll or increase your coverage.

When to Enroll, Change or Cancel Coverage

You can enroll **only** within the 30 calendar days after your employee coverage ends (or by the date on the enrollment notice form, if later). After this 30-day period, you are no longer eligible for retiree life. You can elect the same amount or less of the Basic, Supplemental and/or Executive Basic Life (reduced by any accelerated benefit option payments you've received) in effect on the date when your employee coverage ended. Any reduced amount of coverage you elect must be in an annual salary increment that was in effect on the day you became eligible for retiree life. Any partial amounts will be eligible for continuation with the insurer.

You can decrease or cancel your retiree life coverage at any time. You can decrease your coverage only in increments of the amount of your salary in effect on the day you became eligible for retiree life.

When Coverage Begins

Coverage will begin on the first day of the month following the termination of your employee coverage, provided you enroll by the deadline on the enrollment notice form. Changes in coverage will be effective the first day of the month coincident with or following your enrollment action. Cancellations of coverage will be effective the last day of the month of your enrollment action.

What the Plan Costs

You pay the entire cost of your retiree life coverage.

- The cost of 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.
- The cost of 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 participant, 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 Retiree Life Plan Works

You elect the amount of retiree life coverage you wish to continue and you pay 100% of the monthly premium. You can elect the same amount or less of the Basic, Supplemental and/or Executive Basic Life (reduced by any accelerated benefit option payments you've received) in effect on the date when your employee coverage ended.

Imputed Income

If you became eligible for Company-paid retiree life coverage under your heritage company provisions:

In general if the value of your Company-paid retiree life coverage is $50,000 or greater at any time during a tax year, the cost of that coverage in excess of $50,000 is treated as taxable income for that tax year (called imputed income).

Also, if your employment ended after Dec. 31, 1988, the tax law requires that FICA (Social Security) taxes be paid on this imputed income. The Company has elected to pay your share of these FICA taxes on your behalf, and this represents additional income to you. Income tax is not withheld on either the imputed income for group retiree life or the amount paid on your behalf for the FICA taxes. If you have an imputed income amount subject to tax, you'll receive a notice and a W-2 form from the Company before January of the following 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 life coverage if you're diagnosed as terminally ill with 24 months or less to live, apply prior to age 63 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.

The accelerated benefit is payable only once. You'll continue to make payments for the full amount of coverage as long as you're covered as a retiree.

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

How Benefits Are Paid

The Group Retiree Life Plan will pay benefits to your designated beneficiary(ies).

"Naming or Changing Your Beneficiary," page F-7

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 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 retiree life benefit payments made under this Plan 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.

- 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://mybenefits.conocophillips.com* 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[1]) make the designation.

[1] *Does not apply to heritage Burlington Resources retirees.*

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; or
- Your designated primary and contingent beneficiaries die before you, 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 Retiree Life Plan, your beneficiary or a family member should initially 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.

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 G-24

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 G-20

The Benefits Center is the initial point of contact for all notice of claim submissions under the Group Retiree 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

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 Retiree Life coverage ends, you may be eligible to continue coverage through conversion to an individual policy.

"Continuation of Coverage," at right

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

- The last day of the month in which you no longer meet the Plan's eligibility requirements;

  "Retiree Eligibility," page F-3
- The last day of the month in which you don't pay the required costs for retiree life coverage;
- 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 reach age 65;
- The date on which you are eligible for group life as an employee, if you are rehired by the Company or if your employment status changes;
- The date of your death;
- The date on which the Company terminates relevant coverage (Basic Life and/or Supplemental Life coverage); or
- The date on which the Group Retiree Life Plan is terminated.

Continuation of Coverage

Contact the Claims Administrator to determine if you are eligible for conversion provisions of your retiree life coverage as offered by the insurer.

Some rules apply to retiree 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 all or a portion of your Company group coverage ends.
- If you die within the 31-day continuation-election period, the amount of coverage you had prior to the date of coverage termination will be paid to your beneficiary(ies).
- The participant will be billed monthly by the insurer.

For information about continuation of coverage, contact the Claims Administrator's office that administers conversion.

"Contacts," page A-1

Other Information/ERISA

G

Introduction

This section provides you with general information about many ConocoPhillips retiree benefit plans. It also provides information you're required to receive under the Employee Retirement Income Security Act of 1974 (ERISA).

If you are enrolled in the **Retiree Medical Age 65 and Over or Retiree Dental Plans**, a separate Evidence of Coverage will be provided to you. The Evidence 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

This chapter does not apply to these retiree groups:

- Heritage Burlington Resources Copper Range retirees
- Heritage Tosco retirees under a Senior Executive Retirement Plan
- Heritage Tosco El Dorado union-represented retirees

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

"Glossary," page H-1

Only the following sections apply to the ConocoPhillips Houston Onsite Medical Clinic Former Employee Plan:

- What Else You Should Know
- Your ERISA Rights
- Claims and Appeals Procedures
- ERISA Plan Information

What Else You Should Know

Administrative Information

The information in this section applies to each of the following plans unless provided otherwise:

- ConocoPhillips Retiree Medical and Dental Plan ("Retiree Medical Pre-Age 65 Plan," "Retiree Medical Age 65 and Over Plan," "Retiree Dental Plan" or "Houston Onsite Medical Clinic Former Employee Plan"); and
- ConocoPhillips Group Retiree Life Plan ("Retiree Life Plan" or "Group Retiree Life Plan").

On January 1, 2024, the portion of the ConocoPhillips Group Life Insurance Plan covering retirees and their eligible dependents and another ConocoPhillips employee benefit plan were merged with and into the ConocoPhillips Retiree Medical and Dental Plan. The portion of the ConocoPhillips Group Life Insurance Plan covering retirees and their eligible dependents was then renamed the ConocoPhillips Group Retiree Life Plan, and the ConocoPhillips Retiree Medical and Dental Plan was renamed the ConocoPhillips Retiree Welfare Benefit Plan (the "Retiree Wrap Plan"). For convenience, the word "Plan" is used in this section to refer to the Retiree Wrap Plan and any and/or all the component plans under the Retiree Wrap Plan that are described in this SPD. Another ConocoPhillips employee benefit plan under the Retiree Wrap Plan is described in a separate summary plan description.

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 Retiree Medical and Dental Plan ConocoPhillips Group Retiree Life 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 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.

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 and Houston Onsite Medical Clinic Former Employee Plan) 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)

Retiree Medical Pre-Age 65 Plan and the Houston Onsite Medical Clinic Former Employee Plan

The Retiree Medical Pre-Age 65 Plan and the Houston Onsite Medical Clinic Former Employee 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; or
  - 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 Retiree Medical Pre-Age 65 and Houston Onsite Medical Clinic Former Employee 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 Retiree Welfare Benefit 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.

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 Retiree Medical and Dental 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 Retiree Medical Age 65 and Over Plan, Retiree Dental Plan or the Houston Onsite Medical Clinic Former Employee Plan.

"COBRA Continuation Coverage," page G-10

With regard to the self-insured medical options of the Retiree Medical Pre-Age 65 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 Group Retiree Life Plan, if the Plan is terminated or if benefits are eliminated from the Plan, benefits will be paid 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).

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 but excludes Retiree Medical Age 65 and Over Plan and the Houston Onsite Medical Clinic Former Employee Plan) 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 G-10

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.

- 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.

- **For More Information**

  If you have any questions about the Plan, contact the Benefits Committee or Claims Administrator.

  "Plan Administration," page G-4; "Claims Administrators and Appeals Administrators," page G-22; "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.

COBRA Continuation Coverage

NOTE: The Retiree Medical Age 65 and Over and Retiree Dental Plans are not eligible for COBRA continuation coverage.

Domestic partners and their children will be eligible to elect COBRA coverage for the Retiree Medical Pre-Age 65 Plan, if they were covered under the Plan prior to a qualifying event.

The "When Coverage Ends" section included in the Retiree Medical – Pre-Age 65 chapter explains when your or your dependents' coverage would ordinarily end under the 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 information in this section applies only to ConocoPhillips Retiree Medical Pre-Age 65 Plan coverage and excludes the Houston Onsite Medical Clinic Former Employee Plan. An initial notice is furnished to covered participants 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.)

Special Considerations in Deciding Whether to Elect COBRA Medical Coverage

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 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 G-12

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. Individuals with such a right are called qualified beneficiaries.

"Qualifying Events & Maximum Duration of COBRA Continuation Coverage," page G-12

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 G-12
- 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 G-5

Note: Each qualified beneficiary can make his or her own independent COBRA election. COBRA is not available to surviving spouses who remarry.

Qualifying Events & Maximum Duration of COBRA Continuation Coverage

For medical, 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
Your divorce or legal separation[2]	Your spouse and other affected covered dependents	36 months after loss of coverage due to divorce or legal separation
Your dependent child, domestic partner or domestic partner's children no longer meet eligibility requirements[3]	The affected covered dependent	36 months after loss of coverage due to a change in eligible dependent status
Your coverage ends because you are no longer receiving long-term disability plan benefits and are not eligible for retiree medical coverage otherwise	You and your covered dependents	18 months after the long-term disability plan benefits end
A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to the Company after your termination from the Company	You, your covered dependents and any child born to you, adopted by you or placed for adoption with you during your period of COBRA coverage	You, until your death; your covered dependent(s) and children acquired during COBRA continuation coverage, 36 months after your death

[1] *Regardless of the number of qualifying events, the maximum COBRA continuation coverage is 36 months.*

[2] *If a covered participant 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 participant 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.*

[3] *In this section, "domestic partner" means the domestic partner of the covered participant 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.*

Second Qualifying Event Extension of COBRA Continuation Coverage

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 following your termination of long-term disability benefits. The maximum extension when a second qualifying event occurs is to a total of 36 months of COBRA coverage.

"Qualifying Events," page G-11

- Second qualifying events include the death of a participant, divorce or legal separation from the participant 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 participant becomes enrolled in Medicare.)
- 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 or your long-term disability benefits end and you are not otherwise eligible for retiree medical coverage.
- 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 date of 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.

- **If a COBRA election is not returned 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

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. Because rules may vary depending on your employment status on the event date, check with the COBRA Administration prior to adding dependents. 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 Retiree Medical – Pre-Age 65 chapter of this handbook for further information about a change in status and timeframes.

"Changing or Cancelling Your Coverage," page B-13

You must notify the COBRA Administrator 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 retiree and company 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.

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 by 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.

✔ 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

You may enroll in both the COBRA continuation coverage under the Retiree Medical Pre-Age 65 Plan and in group health coverage under a different employer. However:

- If you elect COBRA continuation coverage under the Retiree Medical Pre-Age 65 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-51; "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 Retiree Medical Pre-Age 65 Plan, you may have both coverages — if you are willing to pay for both plans. If you elect to continue both COBRA under the Retiree Medical Pre-Age 65 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 Retiree Medical Pre-Age 65 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 G-12

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 plan[1];
- On the date the qualified beneficiary first becomes enrolled in Medicare benefits under Part A, Part B or both[1];
- On the date that the Company ceases to provide any group health plan coverage to any retiree;
- On the date the qualified beneficiary fails to pay the full monthly COBRA contribution for continuation coverage on a timely basis; and

  "Paying for COBRA Continuation Coverage," page G-15

- On the date coverage is terminated for any reason the Plan would terminate coverage for a non-COBRA Plan participant.

[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

HIPAA Privacy Rules

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 G-5
- 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.

Genetic Information Nondiscrimination Act: The ConocoPhillips Retiree Medical and Dental Plan does not collect or use genetic information, including family medical history, to determine eligibility for enrollment or for underwriting purposes. The Plan does not require genetic testing and will not use genetic information to determine premium or Company contribution amounts.

The information in this section applies to the ConocoPhillips Retiree Medical and Dental Plan (excludes the Houston Onsite Medical Clinic Former Employee 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 and dental coverage:**
  - 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).

Limitations of PHI Access and Disclosure

The persons described in the section on page G-19 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.

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 Retiree Medical Age 65 and Over or Retiree Dental Plans, except for appeals on eligibility to participate in the Plan. Those plans have their own procedures, which will be communicated by their Claims Administrator.

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 Former Employee 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);
  - 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 G-28), 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 Retiree Medical Pre-Age 65 and Houston 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 G-24, you can request an external review or file suit prior to exhausting the entire process.
- **For life claims,** you cannot sue in federal court before 60 days after proof of loss was submitted. Your suit must be filed within three years[1] from when proof of loss was required.

[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
Retiree Medical Plan		
Eligibility to Participate (includes eligibility for a disabled child and includes the Retiree Medical Age 65 and Over Plan)	N/A *(only one level of appeal is provided, and it's with the Appeals Administrator shown at right)*	
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
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 Former Employee Plan		
Eligibility to Participate	N/A *(only one level of appeal is provided, and it's with the Appeals Administrator shown at right)*	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

(continued)

Type of Benefit	Appeals Administrator — First Level	Appeals Administrator — Second Level
Retiree Dental Plan		
Eligibility to Participate	N/A *(only one level of appeal is provided, and it's with the Appeals Administrator shown at right)*	ConocoPhillips Company Benefits Committee P.O. Box 4783 Houston, TX 77210 (918) 661-5381 or (877) 812-7547
Retiree Life Plan		
Life	N/A *(only one level of appeal is provided, and it's with the Appeals Administrator shown at right)*	The Hartford Group Life Claims Unit PO Box 2999 Hartford, CT 06104-2999 (888) 563-1124

For convenience, the appeals procedures described on page G-24 are grouped by type of benefit:

- Health and welfare plan appeals (Medical, Houston Onsite Medical Clinic and Life claims).

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 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.

With respect to medical and Houston Onsite Medical Clinic 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.

✔ 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.

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 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

Retiree Medical Pre-Age 65 and Houston Onsite Medical Clinic Former Employee Plan 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:
Urgent Care Claims	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 Claims Administrator 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 Claims Administrator 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).
Pre-Service Claims	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 Claims Administrator 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 Claims Administrator received your response to the request for more information.
Concurrent Care Claims	If you file an urgent care claim to extend an approved treatment plan, you will receive a decision **within 24 hours after the request is received**.[1]	No extension if claim is considered urgent. If claim is not urgent, then use same provisions as above for pre-service claims.
	If the Plan shortens or withdraws approval of a treatment plan, **you will be provided advance notice**.[2]	Extension does not apply.
Post-Service Claims	Within a reasonable time after the claim is received, but not longer than 30 days.	(Same provisions as above for pre-service claims)

[1] *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.*

[2] *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 Houston Onsite Medical Clinic claims). See the "Expedited External Review" section for more information.*

"Expedited External Review," page G-32

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.

Life 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:
Life	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 Claims Administrator 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;
- 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.

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 and Houston Onsite Medical Clinic Former Employee Plan Claims," page G-25

Additional Information Included for Medical and Houston Onsite Medical Clinic 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 or Houston 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 or Houston Onsite Medical Clinic urgent care claim, a description of the expedited appeals procedure that applies to urgent care claims; and
- Any additional requirements that may result from new regulations issued, including rights related to health care reform legislation.

✔ If your denied claim was a medical or Houston Onsite Medical Clinic urgent care claim, the notice may be given to you orally first, followed by written or electronic notice within three days.

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.

- 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 and Houston Onsite Medical Clinic claim denial; and
  - Within 60 days for a life claim denial.

  To expedite your appeal, please indicate in large letters at the top of your letter that your letter is an appeal.

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 or Houston 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 Houston 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 G-22; "Expedited External Review," page G-32

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, Houston Onsite Medical Clinic and dental 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 G-29 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 G-29

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 for Retiree Pre-Age 65 Medical, or Houston Onsite Medical Clinic Former Employee *(including eligibility)*	Within a reasonable time after the appeal is received, but not longer than 30 days	No extension allowed
Life	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 or Houston Onsite Medical Clinic.*

Special Rule for Urgent Care Appeals *(Applicable to Medical and Houston 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 G-32.

"Expedited External Review," page G-32

For life 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 G-27.

If your denied appeal was a medical or Houston 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.

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 the Life Plan.

Second Level Appeal to Appeals Administrator

If the first level Appeals Administrator denies your medical or Houston 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 G-22

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 G-28

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.

External Reviews

(Applies to Retiree Pre-Age 65 Medical Claims Only)

Availability of External Review

If, after exhausting the two levels of appeal[1], 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, 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 G-32

[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.*

External Review Process & Timeline

Step in External Review Process	Timeframe
Request for external review 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 external review 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 IRO and must provide all information that was used in determining your denied appeal to the IRO within:	Five business days of assignment of IRO. If this is not done, the IRO may stop its review and reverse the Benefits Committee's decision. The IRO will notify you and the Benefits Committee of this action within one business day of the reversal decision
Once assigned, the IRO will notify you that your external review request has been accepted for review and you can provide additional information to the IRO within:	Ten business days following receipt of notice from IRO
The IRO 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 IRO within:	One business day of decision
If the Benefits Committee does not reverse its denial, the IRO 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 IRO's 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. If medical or Houston 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.

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 another ConocoPhillips employee benefit plan described in a separate summary plan description, 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 Retiree Wrap Plan is 552.

The plan year for the Retiree Wrap Plan begins on January 1 and ends on December 31 each year.

ConocoPhillips Retiree Medical and Dental Plan *(Commonly referred to as the Retiree Medical Pre-Age 65 Plan, the Retiree Medical Age 65 and Over Plan, the Retiree Dental Plan and the Houston Onsite Medical Clinic Former Employee Plan)*	
Type of Benefit	Group health benefits
Plan Funding/Sources of Contributions	The medical options provided under the Retiree Medical Pre-Age 65 Plan are self-insured by ConocoPhillips Company. Any participant 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. The options provided under the Retiree Medical Age 65 and Over Plan and Retiree Dental Plan benefits are funded pursuant to insurance contracts. The costs are paid entirely by participating retirees (excluding certain grandfathered cost-sharing provisions as explained in Appendix I). Costs for Retiree Dental are paid entirely by the participating retirees. The Company pays reasonable expenses necessary for the operation of the Houston Onsite Medical Clinic. Participants are not required to make contributions to have access to medical services at fixed rates and the Plan is not insured.
Plan Medical Director	General Manager, Health Services & CMO

ConocoPhillips Group Retiree Life Plan *(Commonly referred to as the Retiree Life Plan)*	
Type of Benefit	Life benefits
Plan Funding/Sources of Contributions	Benefits are funded through insurance contracts. The costs of life benefits are paid entirely by participating retirees (grandfathered cost-sharing provisions that include Company-paid life coverage are explained in Appendix II). *"Appendix II," page J-1*

Glossary

H

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.

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.

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.

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, there are two types of deductibles — the annual individual deductible and the annual family deductible. The Plan defines the amounts that apply to the annual deductible.

"Some Basic Terms – Annual Deductible," page B-27

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-28

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 G-22

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.

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.

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.

copay (also known as a copayment): The fixed amount of a covered expense that you're responsible for paying.

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.

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.

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.).

disabled *(for Retiree Medical Plans, Retiree Dental and the Houston Onsite Medical Clinic Former Employee 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.

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.

eligible dependent *(for Retiree Medical Plans, Retiree Dental and the Houston Onsite Medical Clinic Former Employee Plan)*:

For the Plans shown below:	The applicable definition is shown in each chapter's "Dependent Eligibility" section:
Retiree Medical — Pre-Age 65	*"Dependent Eligibility," page B-7*
Retiree Medical — Age 65 and Over	*"Dependent Eligibility," page C-4*
Houston Onsite Medical Clinic Former Employee Plan	*"Dependent Eligibility," page D-3*
Retiree Dental	*"Dependent Eligibility," page E-5*

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.

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.

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).

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 Retiree Medical Plans, Retiree Dental and the Houston Onsite Medical Clinic Former Employee Plan)*: A foreign-born child adopted by a (i) covered retiree and/or his or her eligible spouse or (ii) covered retiree'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 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 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.

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.

grandfathered participant-2009: A person identified on Company records with grandfathered eligibility for the Retiree Medical Pre-Age 65 Plan. Includes an employee and any eligible dependent who:

- Is a ConocoPhillips employee whose employment status was regular full-time, and you changed to an employment status or hours not eligible for the ConocoPhillips Employee Welfare Benefit Plan on or after Jan. 1, 2009 and you met all of the eligibility provisions for retiree medical coverage on the date of your status change; or
- Is a ConocoPhillips employee on a leave of absence-Labor Dispute, provided all the other eligibility provisions for retiree medical coverage were met on the day your leave began on or after Jan. 1, 2009.

grandfathered participant-2010: A person identified on Company records with grandfathered eligibility for the Retiree Medical Pre-Age 65 Plan as of Dec. 31, 2009. Includes a retiree and any eligible dependent who:

- Is eligible for the Retiree Medical Pre-Age 65 Plan, but he or she has not contributed at least 40 quarters of Medicare payroll taxes and therefore is not eligible for Medicare Parts A and B; and
- Had a non-U.S. mailing address on Dec. 31, 2009.

group health plan: A plan that provides health care coverage and is maintained by an employer.

heritage Burlington Resources: An individual who meets any of the following criteria:

- He or she was employed by Burlington Resources Inc. or a subsidiary of Burlington Resources Inc. on March 31, 2006 and terminated employment before Jan. 1, 2009; or
- Burlington Resources Inc. or a subsidiary of Burlington Resources Inc. was his or her retiree insurance sponsor on March 31, 2006; or
- He or she was paid from the heritage Burlington Resources Inc. payroll system between March 31, 2006 and April 1, 2007 and terminated employment before Jan. 1, 2009.

heritage Burlington Resources Copper Range retiree:

- A salaried employee who retired prior to Nov. 1, 1975 and who was eligible for a pension (excludes deferred vested pensioners); or
- An employee represented by the United Steelworkers of America bargaining unit on or after Aug. 1, 1980 (the date of the Insurance Agreement between White Pine Copper Division and United Steelworkers of America and as amended by the Memorandum of Agreement between The Louisiana Land and Exploration Company (LL&E) and the United Steelworkers of America dated Jan. 24, 1985); or
- An employee in a group of employees designated by Copper Range Company as covered by the Medical and Retired Life Program.

heritage Burlington Resources Inc. retiree:
An employee who terminated employment prior to Jan. 1, 2009 and who meets one of the conditions below:

1) He or she was a Burlington Resources employee who remained in continuous employment with Burlington Resources Inc. or one of its subsidiaries from March 31, 2006 through March 31, 2007 and retired after March 31, 2007 but prior to Jan. 1, 2009, and who does not meet the 65-point rule for eligibility for ConocoPhillips retiree medical coverage (those employees who met the 65-point rule and other eligibility provisions and elected subsidized ConocoPhillips retiree medical benefits would be a ConocoPhillips retiree); or

2) He or she terminated employment prior to or on March 31, 2007 and did not decline to participate in his/her Burlington Resources Inc.'s employer's retiree medical/dental coverage when he/she was first eligible and:
   - Was not covered by a collective bargaining agreement when in active employment with their then employer; and
   - Either (i) retired by reaching age 55 with 10 years of credited service or age 65 with 5 years of credited service under the Burlington Resources Inc. Pension Plan; (ii) for employees who first become eligible to participate as a retiree on or after Feb. 28, 1993, terminated with five years of credited service under the provisions of the Pension Plan, the Burlington Northern Inc. Pension Plan, or a pension plan sponsored by Burlington Resources Oil and Gas Company (formerly known as Meridian Oil Inc.), El Paso Hydrocarbons Company, BR Services Inc., Burlington Resources Inc., Glacier Park Company, Meridian Minerals Company, Southland Royalty Company or The El Paso Company and affiliated companies; or (iii) on and after Feb. 28, 1993, was age 50 or older with at least five years of credited service (as defined under the Pension Plan) on the date the employee terminates employment with Burlington Resources Inc.; or

3) He or she (i) first became eligible to participate in the Burlington Resources Inc. Retiree Health Care Program prior to Jan. 1, 1995 and had a position that required a normal work week of at least 32 hours per week in the employ of Burlington Resources Inc. immediately prior to retirement; or (ii) first became eligible to participate in the Burlington Resources Inc. Retiree Health Care Program on or after Jan. 1, 1995, was enrolled in the Burlington Resources Inc. Comprehensive Medical Expense Plan in the year of retirement or termination and in the immediately preceding calendar year. In addition, the individual must have elected to participate in his or her employer's retiree medical and dental coverage when first eligible and cannot have been covered by a bargaining agreement when in active employment; or

4) He or she (i) was a CIC Participant as defined under the Burlington Resources Inc. Employee or Executive Change in Control Severance plan at the time of the acquisition of Burlington Resources Inc. (ii) met the retiree medical eligibility requirements under the then available retiree medical coverage and (iii) made an election to participate in retiree medical coverage within thirty (30) days upon termination of their CIC Health Coverage immediately following termination of their CIC Health Coverage or who chose to defer enrollment in retiree medical coverage until a later date.

With respect to the following companies, the term "eligible heritage Burlington Retiree" will include only those employees described in items 1 – 4 above who are also:

- Retired or terminated and exempt, salaried or hourly employees of Burlington Resources Oil and Gas Company (formerly known as Meridian Oil Inc.) or El Paso Hydrocarbons Company; or
- Retired or terminated and exempt or salaried employees of BR Services Inc., Burlington Resources Inc., Glacier Park Company or Meridian Minerals Company.

heritage Burlington Resources Inexco retiree: An individual who is listed in the Company plan-approval documents for heritage Burlington Post-1986 Louisiana Land & Exploration (LL&E) retiree group as an Inexco retiree.

heritage Burlington Resources Post-1986 Louisiana Land & Exploration (LL&E) retiree: An employee of The Louisiana Land & Exploration Company who on and after Jan. 1, 1986 was or became eligible to retire (by reaching age 50 with 10 years of credited service under the LL&E Pension Plan) on or before Dec. 31, 1998 and who actually retired from LL&E on or before Dec. 31, 1999. This group includes certain heritage Burlington Resources Inexco retirees as listed on the Company plan-approval documents.

heritage Burlington Resources Pre-1986 El Paso retiree: An employee who terminated employment:

1) On or before March 1, 1986 from El Paso Hydrocarbons Company or Burlington Resources Oil and Gas Company[1] (but excluding former Milestone Petroleum Employees who terminated prior to Jan. 1, 1985) on or after becoming eligible for an early or normal retirement benefit under the pension plan of their employer at the time of retirement;
2) On or before Sept. 1, 1986 from Southland Royalty Company and who is listed in the Company plan-approval documents;
3) Prior to Jan. 1, 1985 from The El Paso Company and Affiliated Companies (Burlington Resources Inc, BR Services Inc., Glacier Park Company, Meridian Minerals Company, Burlington Resources Oil and Gas Company[1], El Paso Natural Gas Company, Plum Creek Timber Company, Inc., Plum Creek Management Company, The Louisiana Land and Exploration Company) and who was covered as a retired employee under the former health plan maintained by The El Paso Company.

Also includes for retiree life insurance eligibility purposes only those retirees who were employees on Dec. 31, 1984 of any of the companies listed in "1" and "3" above and who were participants in the Employee Retirement Income Plan of the El Paso Company and Affiliated Companies (prior retirement plan of these companies) because of eligibility for a special post-retirement Burlington Resources Inc. Pension Plan death benefit.

heritage Burlington Resources Pre-1986 Louisiana Land & Exploration (LL&E) retiree: An employee of The Louisiana Land & Exploration Company (LL&E) who terminated employment prior to Jan. 1, 1986 from LL&E by reaching age 50 with 10 years of credited service under the LL&E Pension Plan.

[1] *Formerly known as Meridian Oil Inc.*

heritage Conoco: Designation created on Aug. 30, 2002 (merger closing date). Upon the merger of Conoco Inc. and Phillips Petroleum Company, all employees and retirees were assigned to a heritage company. An individual was designated "heritage Conoco" if they met any of the following criteria:

- He or she was employed by Conoco or a subsidiary of Conoco on Aug. 30, 2002 or was paid from the heritage Conoco payroll system between Aug. 31, 2002 and Dec. 31, 2002, and terminated employment before Jan. 1, 2007; or
- Conoco or a subsidiary of Conoco was his or her retiree insurance sponsor on Aug. 30, 2002; or
- He or she was a former employee or disabled former employee who was eligible for retirement benefits at the time his or her employment ended (see eligibility criteria defined under the Heritage Conoco section in Appendix I or Appendix II of this handbook); or

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- He or she was hired by ConocoPhillips or a subsidiary of ConocoPhillips between Jan. 1, 2003 and Dec. 31, 2006 and he or she or the surviving dependent subsequently became eligible for retiree benefits in that period; or
- He or she was approved for Long-Term Disability benefits and terminated employment between Jan. 1, 2003 and Dec. 31, 2006 (or would have been approved if he or she had been enrolled in the Plan).

heritage Phillips: Designation created on Aug. 30, 2002 (merger closing date). Upon the merger of Conoco Inc. and Phillips Petroleum Company, all employees and retirees were assigned to a heritage company. An individual was designated "heritage Phillips" if they met any of the following criteria:

- He or she was employed by Phillips or a subsidiary of Phillips on Aug. 30, 2002 or was paid from the heritage Phillips payroll system between Aug. 31, 2002 and Dec. 31, 2002, and terminated employment before Jan. 1, 2005; or
- Phillips or a subsidiary of Phillips was his or her retiree insurance sponsor on Aug. 30, 2002; or
- He or she was a former employee or disabled former employee who qualified for retirement benefits at the time his or her employment ended (see eligibility criteria defined under the Heritage Phillips section in Appendix I or Appendix II of this handbook).

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heritage Tosco: Designation created on Aug. 30, 2002 (merger closing date). Upon the merger of Conoco Inc. and Phillips Petroleum Company, all employees and retirees were assigned to a heritage company. An individual was designated "heritage Tosco" if they met any of the following criteria:

- He or she was employed by Tosco or a subsidiary of Tosco on Aug. 30, 2002 or was paid from a heritage Tosco payroll system between Aug. 31, 2002 and Dec. 31, 2002, and terminated employment before Jan. 1, 2007; or
- Tosco or a subsidiary of Tosco was his or her retiree insurance sponsor on Aug. 30, 2002 (closing date) ; or
- He or she was a former employee or disabled former employee who qualified for retirement benefits at the time his or her employment ended (see criteria defined under the Heritage Tosco section in Appendix I or Appendix II of this handbook).

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heritage Tosco El Dorado union-represented retirees: An individual who retired from a union-represented position at the El Dorado, Arkansas refinery that was purchased by Tosco.

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 Retiree Medical Pre-Age 65 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.

incapacity retirement (heritage Conoco): An employee who became disabled prior to Jan. 1, 2003 while employed by heritage Conoco after completing a minimum of 10 years of service and who was age 40 or older at termination.

Independent Review Organization (IRO): An entity that conducts independent external reviews of denied claims and appeals under federal external review procedures approved by National Association of Insurance Commissioners. Also known as External Review Organization (ERO) by some Claims Administrators.

ineligible dependent: A dependent who does not meet a Plan's dependent eligibility requirements or is otherwise disqualified from eligibility.

ineligible Phillips 66 retiree: An individual who transferred to a member of the Phillips 66 controlled group on April 30, 2012 in connection with the distribution of Phillips 66 shares to the shareholders of ConocoPhillips, and was not enrolled in one or more of the ConocoPhillips retiree plans (Retiree Medical Under Age 65, Retiree Medical Age 65 and Over, Retiree Dental) on July 1, 2015. After July 1, 2015, an ineligible Phillips 66 retiree and his or her eligible dependents will no longer be eligible for the aforementioned three ConocoPhillips retiree plans. These provisions also apply to any surviving dependents of the ineligible Phillips 66 retiree. If an ineligible Phillips 66 retiree later becomes eligible for the ConocoPhillips retiree plans due to being hired by ConocoPhillips, he/she will no longer be considered an ineligible Phillips 66 retiree.

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).

leave of absence: A direct U.S. dollar payroll status (also known as "inactive employee status") that may 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. For the leave of absence-Labor Dispute, the Company places an active employee on this leave for the time when he/she is not working due to a labor dispute, and generally benefits are not available during the leave.

legally adopted *(for Retiree Medical Plans, Retiree Dental and the Houston Onsite Medical Clinic Former Employee Plan)***:** For a child (must be under age 18) to be considered the legally adopted son or daughter of the (i) covered retiree and/or the covered employee's eligible spouse or (ii) covered retiree'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 retiree and/or his or her spouse or (ii) covered retiree'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.

lifetime maximum *(for Retiree Medical Pre-Age 65 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.).

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 Retiree Medical Pre-Age 65 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.

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.

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 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-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 provider who has not contracted to furnish services or supplies at a negotiated rate.

non-store: Employee jobs that are **not** classified in the personnel systems of the employer as retail marketing store.

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.***

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 Retiree Medical Pre-Age 65 Plan and Retiree Dental)***:** 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 benefit under the Group Retiree Life Plan)***:** A person who is:

- A 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 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 Retiree Medical Plans, Retiree Dental and the Houston Onsite Medical Clinic Former Employee 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 retiree 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 retiree for the purpose of legally adopting the child and imposes a legal obligation on the covered retiree for partial or total support of the child or (ii) a legally binding contract between the covered retiree 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 retiree for the purpose of legally adopting the child and imparts an obligation on the covered retiree 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 and dental plans will be post-service claims.

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-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.

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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 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.

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 Retiree Medical Pre-Age 65 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 charges, 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 in the left-hand column, 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.

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.

"Contacts," page A-1

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.

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 to the right.

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.

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.

service area: Area served by UnitedHealthCare Medicare Advantage Prescription Drug which is all states of the United States, District of Columbia and all U.S. territories.

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.

store employee: Employee in a job classified as retail marketing store (including store manager and store manager in training) in the personnel systems of the employer.

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.

support *(for Retiree Medical Plans, Retiree Dental and the Houston Onsite Medical Clinic Former Employee 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 Retiree 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.

true out-of-pocket (TrOOP) costs: What you and others on your behalf pay for your Medicare Part D covered prescription drugs. Includes what you pay as an annual deductible, copay and coinsurance.

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.

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 Retiree Medical Pre-Age 65 Plan will treat a claim as an urgent care claim if the physician 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.

valid beneficiary designation: Under the Group Retiree Life Plan options, a Claims Administrator-approved form for the applicable Plan that's completed either online at *http://mybenefits.conocophillips.com* 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.

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.

well vision exam: A comprehensive eye examination to evaluate and treat vision problems and related diseases.

Appendix I — Grandfathered Retiree Medical and Dental Insurance Benefit Provisions

Introduction

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

"Glossary," page H-1

Information in this Appendix explains retiree eligibility and cost sharing. Dependent eligibility and when you can enroll, unless noted here otherwise, are explained in the appropriate medical or dental SPD chapter.

Benefit plan names in this Appendix reflect name on effective date and not subsequent plan name changes.

A Company contribution, if any, for **Retiree Medical Age 65 and Over Plan** coverage applies only to Group Medicare Advantage (PPO) coverage.

A Company contribution, if any, for the **HDHP or HDHP Base retiree medical options** includes both medical and prescription drug coverage.

The information in this chapter provides specific benefit provisions that differ from the current retiree Plan provisions due to grandfathering of heritage plan provisions. Information in this Appendix is broken down by company name and by the applicable criteria for appropriate provision differences, and may be limited by medical plan late enrollment provisions. This Appendix is designed to be used in conjunction with the applicable retiree medical and dental chapters.

"Retiree Medical – Pre-Age 65," page B-1; "Retiree Medical – Age 65 and Over," page C-1; "Retiree Dental," page E-1

Medical & Dental Eligibility and Cost Sharing

Heritage Burlington Resources Inc. Retirees

The information in this section applies to you if you were a heritage Burlington Resources Inc. retiree and your employment ended on or before Dec. 31, 2008.

If You Meet the Following Eligibility Requirements:	Your Medical and Dental Cost Sharing Will be:
Your employment ended on or before March 31, 2007	You pay 100% of the medical rate (rate band "02") and 100% of the Retiree Dental – MetLife[1] rate.
• You remained in continuous employment with Burlington Resources Inc. or one of its subsidiaries from March 31, 2006 through March 31, 2007; • Your termination date was between April 1, 2007 and Dec. 31, 2008; and • You do **not** meet the 65-point rule.	You pay 100% of the medical rate (rate band '02') and will be considered a heritage Burlington Resources Inc. retiree. You pay 100% of the Retiree Dental – MetLife[1] rate if your termination date is **before** Oct. 1, 2008. You pay 100% of the Retiree Dental rate if your termination date is **on or after** Oct. 1, 2008.
• You remained in continuous employment with Burlington Resources Inc. or one of its subsidiaries from March 31, 2006 through March 31, 2007; • Your termination date was between April 1, 2007 and Dec. 31, 2008; and • You meet the 65-point rule and you are an eligible heritage Burlington Resources Inc. retiree.	You may elect: • The ConocoPhillips retiree medical coverage with a Company contribution[2] (you'll be considered a ConocoPhillips retiree). If you elect this option, you're eligible for the Retiree Dental Plan without a Company contribution; or • The retiree medical coverage without a Company contribution (rate band "02") (you'll be considered a heritage Burlington Resources Inc. retiree). If you elect this option, you're eligible for retiree dental without a Company contribution (Retiree Dental – MetLife[1] if your termination date is **before** Oct. 1, 2008; Retiree Dental if your termination date is **on or after** Oct. 1, 2008). **Note:** The company's medical and dental coverage you elect will be the company for your retiree life insurance provisions also.
You're a newly-eligible surviving dependent on or after Jan. 1, 2007.	Medical and dental cost sharing will be the same as it was for the employee/retiree. **Note:** If you were an eligible surviving dependent prior to Jan. 1, 2007, you must have been enrolled as a surviving dependent on Jan. 1, 2007 in order to have coverage thereafter.
You're approved for LTD benefits under Burlington Resources LTD insurance	Your cost sharing depends on your termination date (see above in this chart).

[1] *Effective Jan. 1, 2012, the Retiree Dental – MetLife option was eliminated. Participants may enroll in the Retiree Dental Plan and pay 100% of the rate.*

[2] *Participants (includes retirees and their eligible dependents) who have coverage under the Retiree Medical Age 65 and Over Plan on Dec. 31, 2015 will continue to be eligible to receive Company premium cost-sharing contributions until Dec. 31, 2025, per provisions in effect on Dec. 31, 2015; however, premium cost-sharing contributions will be phased out over a ten-year period with the contributions ending Dec. 31, 2025. This includes participants who were an eligible surviving spouse/domestic partner or dependent of any participant. New participants in the Retiree Medical Age 65 and Over Plan on Jan. 1, 2016 and after pay 100% of the Plan premium.*

Effective Jan. 1, 2021, the Company premium cost-sharing contribution will not be reinstated if you voluntarily terminate your Plan coverage for any reason other than being rehired by the Company. If coverage for you or your eligible dependent(s) for this Plan is terminated due to non-payment, the Company premium cost-sharing contribution will only be reinstated if you pay all back premiums subject to the Claims Administrator's procedures. Effective Jan. 1, 2019, the premium cost-sharing contribution was reinstated one time only if you had become subject to a premium cost share for the first time as a result of the contribution phase out. Effective Jan. 1, 2016, the contribution was not reinstated for any reason other than being rehired by the Company. A rehired retiree and any eligible dependents (who were eligible for the Company premium cost-sharing contribution and covered by the Plan on Dec. 31, 2015) may subsequently re-enroll in the Plan after termination of employment and receive the Company premium cost-sharing contribution, if still available. If the Company contribution is terminated for only the retiree/surviving dependent/long-term disability participant, it can be continued for any of the participant's eligible dependents as long as their individual coverage is not terminated.

Heritage Burlington Resources Post-1986 Louisiana Land & Exploration (LL&E) Retirees AND Heritage Burlington Resources Inexco Retirees

The information in this section applies to you if you were a heritage Burlington Resources Post-1986 Louisiana Land & Exploration (LL&E) retiree or a heritage Burlington Resources Inexco retiree.

Note: Surviving dependents aren't eligible for coverage unless they were enrolled in the Plan on the employee's/retiree's date of death and were still enrolled on Jan. 1, 2007. Surviving dependents are eligible for the retiree's cost-sharing provisions.

✔ Eligibility provisions for these heritage retiree groups are described in the Glossary.

"Glossary," page H-1

Effective on this Date:	The Following Changes Were Made to Retiree Cost-Sharing Provisions
Jan. 1, 2016	Participants (includes retirees and their eligible dependents) who have coverage under the Retiree Medical Age 65 and Over Plan on Dec. 31, 2015 will continue to be eligible to receive Company premium cost-sharing contributions until Dec. 31, 2025, per provisions in effect on Dec. 31, 2015; however, premium cost-sharing contributions will be phased out over a ten-year period with the contributions ending Dec. 31, 2025. This includes participants who were an eligible surviving spouse/domestic partner or dependent of any participant. New participants in the Retiree Medical Age 65 and Over Plan on Jan. 1, 2016 and after pay 100% of the Plan premium. Effective Jan. 1, 2021, the Company premium cost-sharing contribution will not be reinstated if you voluntarily terminate your Plan coverage for any reason other than being rehired by the Company. If coverage for you or your eligible dependent(s) for this Plan is terminated due to non-payment, the Company premium cost-sharing contribution will only be reinstated if you pay all back premiums subject to the Claims Administrator's procedures. Effective Jan. 1, 2019, the premium cost-sharing contribution was reinstated one time only if you had become subject to a premium cost share for the first time as a result of the contribution phase out. Effective Jan. 1, 2016, the contribution was not reinstated for any reason other than being rehired by the Company. A rehired retiree and any eligible dependents (who were eligible for the Company premium cost-sharing contribution and covered by the Plan on Dec. 31, 2015) may subsequently re-enroll in the Plan after termination of employment and receive the Company premium cost-sharing contribution, if still available. If the Company contribution is terminated for only the retiree/surviving dependent/long-term disability participant, it can be continued for any of the participant's eligible dependents as long as their individual coverage is not terminated.
Jan. 1, 2009	For all retirees, regardless of termination date, the 4.5% cap was modified for those in the Retiree Medical Age 65 and Over Plan.
Jan. 1, 2008	For all retirees, regardless of termination date, a 4.5% cap was implemented on annual increases of Company contributions for retiree medical.
Jan. 1, 2007	For all retirees in the Primary PPO option, cost sharing was 50/50, which is 100% of the maximum Company contribution under the 85-point level. Company contribution for Traditional option was the same as the Primary PPO option. For all retirees in the HDHP or EPO option, the Company's contribution was: • ***You + One* coverage:** 50/50; • ***You Only* coverage:** One-half the ***You + One*** contribution amount; and • ***You + Two or More* coverage:** 2.3 times the ***You Only*** contribution amount (the 2.3 multiple is subject to change). Cost sharing for retiree dental coverage was 50/50.
Prior to 2007	Cost sharing was per Burlington Resources provisions.

Heritage Burlington Resources Pre-1986 El Paso Retiree AND Heritage Burlington Resources Pre-1986 Louisiana Land & Exploration (LL&E) Retiree

The information in this section applies to you if you were a heritage Burlington Resources Pre-1986 El Paso retiree or a heritage Burlington Resources Pre-1986 Louisiana Land & Exploration (LL&E) retiree.

✔ Eligibility provisions for this heritage retiree group are described in the Glossary.

"Glossary," page H-1

Note: Surviving dependents aren't eligible for coverage unless they were enrolled in the Plan on the employee's/retiree's date of death and were still enrolled on Jan. 1, 2007. Surviving dependents are eligible for the retiree's cost-sharing provisions.

Prior to Jan. 1, 2012, the Company paid 100% of the medical and dental rates. Effective Jan. 1, 2012, you pay $2.50 per month for option L of the Retiree Medical Age 65 and Over Plan and you pay 100% of the Retiree Dental rate. If you elect another option of the Retiree Medical Age 65 and Over Plan, the Company contribution for that option will be the same as it is for option L. Effective Jan. 1, 2021, you pay $2.50 per month for the ConocoPhillips Core option of the Retiree Medical Age 65 and Over Plan and you pay 100% of the Retiree Dental rate. If you elect the ConocoPhillips Plus option, the Company contribution for that option will be the same as it is for the Core option.

Heritage Conoco

The information in this section applies to you if you were a heritage Conoco individual and your employment ended on or before Dec. 31, 2006.

Eligibility

If You Meet the Following Eligibility Requirements:	Your coverage may be continued as follows:
You were a heritage Conoco employee who took **normal retirement** (age 65 or older, regardless of years of service), and you aren't covered by a collective bargaining agreement that provides for other medical coverage.	You may continue medical coverage for yourself and your eligible dependents. **Note:** Effective Jan. 1, 2005, the requirement that you had to be **enrolled** on your termination date was changed to that you just had to be **eligible** for coverage on that date. If you die, your eligible dependents may continue their coverage per current plan provisions.
You were a heritage Conoco employee who took **early retirement** (age 50 – 64, with at least 10 years of service), and you aren't covered by a collective bargaining agreement that provides for other medical coverage.	You may continue medical coverage for yourself and your eligible dependents. **Note:** Effective Jan. 1, 2005, the requirement that you had to be **enrolled** on your termination date was changed to that you just had to be **eligible** for coverage on that date. If you die and your eligible dependents were covered on the date of your death, your eligible dependents may continue their coverage per current plan provisions.
You were a heritage Conoco employee who was approved for incapacity retirement (age 40 or older with at least 10 years of service) prior to Jan. 1, 2003, and you were totally and permanently disabled at the date of your termination, and continue to meet the disability criteria.	You may continue medical coverage for yourself and your eligible dependents. If you die and your eligible dependents were covered on the date of your death, your eligible dependents may continue their coverage per current plan provisions.
You were a heritage Conoco employee who would have been approved for incapacity retirement had the age and service requirements been satisfied on the date of termination from Conoco.	By paying the total cost of coverage, you may continue coverage for yourself for 29 months from the date you became disabled or until you are eligible for Original Medicare, whichever occurs first. You pay 102% of the cost of coverage for your dependents. When you become eligible for Original Medicare, your eligibility for medical coverage under this Plan ends. However, your covered eligible dependents who aren't eligible for Original Medicare may continue their coverage. New dependents cannot be added after your coverage ends. Coverage for your dependents won't be continued in the event of your death, unless they elect COBRA continuation coverage.

(continued)

If You Meet the Following Eligibility Requirements:	Your coverage may be continued as follows:
You're a surviving spouse/dependent child of a deceased heritage Conoco individual who died before Jan. 1, 2005, and you were covered under a Company medical plan option at the time of the retiree's/employee's death.	You may continue medical coverage.
You're a surviving spouse/dependent child of a deceased heritage Conoco individual who died on or after Jan. 1, 2005, and you were covered under or eligible for a Company medical plan option at the time of the retiree's/employee's death.	You may continue medical coverage or, if not covered, you may enroll if you enroll when initially eligible.
You're a surviving domestic partner of a deceased heritage Conoco individual who died on or after Jan. 1, 2006, and you and the heritage Conoco individual were covered under a Company medical plan option at the time of the retiree's/employee's death.	You may continue medical coverage. **Note:** This provision does not apply to your children.
You're an eligible spouse/dependent child of a heritage Conoco employee who died as a result of an occupational accident, as defined by the Group Life Insurance Plan, prior to Jan. 1, 2003.	If you're already enrolled in the Plan, you may elect to continue your medical coverage under retiree medical provisions. You will pay active employee rates for your coverage prior to Jan. 1, 2003, and retiree rates for coverage after Jan. 1, 2003. Surviving spouse coverage ends if you remarry. Prior to Jan. 1, 2003, if a surviving spouse remarried, surviving dependent children coverage could continue. On and after Jan. 1, 2003, if a surviving spouse remarries someone who is not already covered by the Plan, coverage for his or her surviving dependent children ends.
You're an eligible spouse/dependent child of a heritage Conoco employee who: • Died prior to Jan. 1, 2003 while he or she was covered under the Plan; and • Had 15 or more years of service or was eligible for early retirement (age 50 and at least 10 years of service on the date of death).	If you're already enrolled in the Plan, you may elect to continue your medical coverage. You will pay retiree rates for your coverage and will be eligible for retiree medical options. Company contributions won't be reduced by the retirement plan early reduction factor. Surviving spouse coverage ends if you remarry. Prior to Jan. 1, 2003, if a surviving spouse remarried, surviving dependent children's coverage could continue. On and after Jan. 1, 2003, if a surviving spouse remarries, coverage for a surviving spouse and dependent children is per current plan provisions.
You were a heritage Conoco employee who also is eligible for DuPont retiree benefits.	If you're eligible for heritage Conoco and/or ConocoPhillips or DuPont retiree benefits, you may enroll in DuPont retiree benefits and defer enrollment in the ConocoPhillips Retiree Medical and Dental Plan. You may then enroll in the ConocoPhillips Retiree Medical and Dental Plan at a later date.
You were a heritage Conoco store employee who was age 50 with 10 years of service on Dec. 31, 2002.	You are eligible to enroll in medical coverage when you terminate your employment with a company that is an employer participating in the Plan.
You were a heritage Conoco employee who became eligible between Jan. 1, 2003 and Dec. 31, 2006 due to approval for long-term disability (LTD) benefits (or you would have been approved if you had been enrolled in the plan).	You may continue medical coverage when your employment ends. **Note:** Effective Jan. 1, 2005, the requirement that you had to be **enrolled** on your termination date was changed to that you just had to be **eligible** for coverage on that date.

Cost Sharing

Effective on this Date:	The Following Changes Were Made to the Retiree Medical Cost-Sharing Provisions:
Jan. 1, 2016	Participants (includes retirees and their eligible dependents) who have coverage under the Retiree Medical Age 65 and Over Plan on Dec. 31, 2015 will continue to be eligible to receive Company premium cost-sharing contributions until Dec. 31, 2025, per provisions in effect on Dec. 31, 2015; however, premium cost-sharing contributions will be phased out over a ten-year period with the contributions ending Dec. 31, 2025. This includes participants who were a ConocoPhillips employee eligible for retiree medical because their employment ended due to approval for long-term disability (LTD) benefits on Jan. 1, 2007 or after, and an eligible surviving spouse/domestic partner or dependent of any participant. New participants in the Retiree Medical Age 65 and Over Plan on Jan. 1, 2016 and after pay 100% of the Plan premium. Effective Jan. 1, 2021, the Company premium cost-sharing contribution will not be reinstated if you voluntarily terminate your Plan coverage for any reason other than being rehired by the Company. If coverage for you or your eligible dependent(s) for this Plan is terminated due to non-payment, the Company premium cost-sharing contribution will only be reinstated if you pay all back premiums subject to the Claims Administrator's procedures. Effective Jan. 1, 2019, the premium cost-sharing contribution was reinstated one time only if you had become subject to a premium cost share for the first time as a result of the contribution phase out. Effective Jan. 1, 2016, the contribution was not reinstated for any reason other than being rehired by the Company. A rehired retiree and any eligible dependents (who were eligible for the Company premium cost-sharing contribution and covered by the Plan on Dec. 31, 2015) may subsequently re-enroll in the Plan after termination of employment and receive the Company premium cost-sharing contribution, if still available. If the Company contribution is terminated for only the retiree/surviving dependent/long-term disability participant, it can be continued for any of the participant's eligible dependents as long as their individual coverage is not terminated.
Jan. 1, 2012	For all retirees, regardless of termination date, the 4.5% cap was modified for those in the Pre-65 medical options.
Jan. 1, 2009	For all retirees, regardless of termination date, the 4.5% cap was modified for those in the Retiree Medical Age 65 and Over Plan.
Jan. 1, 2009	For retirees age 65 and over whose termination date was prior to Jan. 1, 2007, the various heritage Conoco retiree medical rates were harmonized by (i) reducing further the number of indexed medical factors, and (ii) converting them to new retiree rate bands. The change maintained or increased the previous indexed medical factor cost sharing.
Jan. 1, 2007	For retirees under age 65 whose termination date was prior to Jan. 1, 2007, the various heritage Conoco retiree medical rates were harmonized by (i) reducing further the number of indexed medical factors, and (ii) converting them to new retiree rate bands. The change maintained or increased the previous indexed medical factor cost sharing. Retirees whose termination date was on or after Jan. 1, 2007 were not eligible for the heritage Conoco retiree rate bands.
Jan. 1, 2006	For retirees whose termination date was prior to Jan. 1, 2006, the various heritage Conoco retiree medical rates were harmonized by (i) reducing the number of indexed medical factors, and (ii) converting them to new retiree rate bands. The change maintained or increased the previous indexed medical factor cost sharing.
Jan. 1, 2003	For heritage Conoco retirees whose termination date was prior to Jan. 1, 2007, a 4.5% cap was implemented on annual increases of Company contributions for retiree medical.
Feb. 1, 1994	Retiree rate bands to determine company contribution percentage using indexed medical factors were implemented based on the first of the month following the retiree's termination date.
Prior to Feb. 1, 1994	Retirees paid the same rate as active employees. **Note:** Employees eligible for retiree medical who retired prior to Feb. 1, 1994 received the maximum company contribution upon later implementation of indexed medical factors and retiree rate bands.

Retiree Medical Rate Bands

The following rate bands apply if your cost sharing method is not based on the 65-point rule:

Pre Jan. 1, 2007 Bands	Jan. 1, 2007 Bands	Retiree's Age at Termination	Percent of Maximum Company Contribution
A	90	59 1/12 or older, terminated prior to Feb. 1, 1994 or approved for incapacity retirement	113%
B	90	58 1/12 to 59	113%
C	90	57 1/12 to 58	113%
D	85	56 1/12 to 57	100%
E	80	55 1/12 to 56	90%
F	80	54 1/12 to 55	90%
G	75	53 1/12 to 54	80%
H	70	52 1/12 to 53	70%
I	65	51 1/12 to 52	60%
J	65	50 1/12 to 51	60%
K	65	50	60%

"What the Plan Costs," page B-14 (Retiree Medical – Pre-Age 65); "What the Plan Costs," page C-8 (Retiree Medical – Age 65 and Over)

Dental

If you and your eligible dependents are eligible for retiree medical coverage, you and your eligible dependents are also eligible for retiree dental coverage. You pay 100% of the Retiree Dental premium as of Jan. 1, 2008.

Heritage Phillips

The information in this section applies to you if you were a heritage Phillips individual and your employment ended on or before Dec. 31, 2004.

Eligibility

If You Meet the Following Eligibility Requirements:	Your Medical Coverage May be Continued as Follows:
You were a heritage Phillips non-store employee or a disabled former employee receiving LTD benefits who had at least 10 years of recognized service when employment ended at any time after reaching early retirement age 55 (per the definition of early and normal retirement age in the Retirement Income Plan of Phillips). **Note:** If you were born before 1950 and were an employee (or former employee receiving LTD benefits) on Dec. 31, 1994, you were exempt from the service requirements. If you were a former employee receiving LTD benefits and not exempt from the service requirement, each full month of LTD benefits counts toward the 10 years of recognized service and age requirement for retiree medical eligibility, beginning with the later of your 45th birthday or your company service date.	If eligible prior to Jan. 1, 2003, you were eligible to enroll. If eligible between Jan. 1, 2003 and Dec. 31, 2004, you had to be enrolled on your termination date to be eligible for coverage. If eligible Jan. 1, 2005 and after, you just had to be eligible for coverage on your termination date. **Note:** If you are a former employee receiving LTD benefits, you are eligible for retiree medical until your LTD benefits end. At that time, you may continue your retiree medical coverage only if you were otherwise eligible for it on your termination date.
You were a heritage Phillips employee born prior to March 1, 1921.	Prior to Jan. 1, 2009, you and/or your eligible dependents could elect to continue your frozen premiums in the Traditional medical option and not have creditable prescription drug coverage under Original Medicare Part D prescription drug coverage (prescription drug retail discount card **only**). If you changed your enrollment to a non-frozen premium, you could have retail and mail-order creditable prescription drug coverage and could no longer elect the frozen premium coverage provision. Effective Jan. 1, 2009, you are eligible only for coverage under the Retiree Medical Age 65 and Over Plan with an increased Company contribution to compensate for the past frozen premium level. The prescription drug retail discount card was discontinued on Jan. 1, 2009. Any disabled eligible dependent with a frozen premium in the Traditional medical option of the Retiree Medical Pre-Age 65 Plan on Dec. 31, 2008 can remain in this option until they reach age 65. In lieu of the prescription drug retail discount card, disabled eligible dependents may receive covered prescription drugs through the Traditional option by paying 100% of the company's contracted rate.
You were a heritage Phillips employee not covered by a collective bargaining agreement that provided other medical coverage when you first became a heritage Phillips retiree (includes employment ending due to layoff): • You had one of the Company medical options or Health Maintenance Organization (HMO) coverage on the day before you became a retiree; or • You had COBRA continuation coverage after you became a retiree.	You may continue medical coverage for yourself and your eligible dependents. **Note:** Effective Jan. 1, 2005, the requirement that you had to be **enrolled** on your termination date was changed to that you just had to be **eligible** for coverage on that date.

(continued)

If You Meet the Following Eligibility Requirements:	Your Medical Coverage May be Continued as Follows:
You were a heritage Phillips employee who became eligible between Jan. 1, 2003 and Dec. 31, 2006 due to approval for long-term disability (LTD) benefits (or you would have been approved if you had been enrolled in the plan).	You are eligible to enroll in retiree medical coverage when you terminate your employment. Your heritage company becomes heritage Conoco for cost-sharing provisions.
You're a surviving spouse/dependent child of a deceased heritage Phillips individual who died before Dec. 31, 2004, and you were covered under a Company medical plan at the time of the retiree's/employee's death.	You may continue medical coverage.
You're a surviving domestic partner of a deceased heritage Phillips individual who died on or after Jan. 1, 2006, and you and the heritage Phillips individual were covered under a Company medical plan option at the time of the retiree's/employee's death.	You may continue medical coverage. **Note:** This provision does not apply to your children.
You were a heritage Phillips employee and your employment with the Company ended by transfer to Duke Energy Field Services L.L.C. ***(DEFS)*** (now DCP Midstream) during or after the calendar year in which you reached age 50.	You may enroll in medical coverage under the retiree medical option of the Plan as a retired employee. The 10-year service requirement doesn't apply.
You were a heritage Phillips Pipeline Relief Pool employee, age 50 – 54, who was enrolled in medical coverage on Dec. 31, 2003, and you transferred to Sentinel.	You may enroll in medical coverage under the retiree medical option of the Plan as a retired employee. The 10-year service requirement doesn't apply.
You were a heritage Phillips store employee who transferred to Circle K Inc. on Sept. 14, 2001.	You're eligible to enroll in retiree medical coverage when you terminate your employment with a company that is an employer participating in the Plan, provided you meet all of the following criteria: • You were age 55 or older as of Dec. 31, 2001; • You had at least 10 years of service as of Dec. 31, 2001; and • You were enrolled in active medical coverage on Dec. 31, 2001.
Your employment ended with the Company due to transfer to ChevronPhillips Chemical Company on Jan. 1, 2001.	If you were a Phillips employee on Dec. 31, 2000, and became a ChevronPhillips Chemicals Company employee on Jan. 1, 2001, you are eligible for retiree medical only if you met all eligibility requirements as of Dec. 31, 2000.

Medical Coverage for Laid Off Employees Who Were Age 50 Through 54 (Unless Otherwise Noted)

If You Were Laid Off on this Date (by Layoff or Sale):	You Have/Had this Medical Coverage Available to You:
Laid off after July 31, 1982, and before April 3, 1986	If you were vested in the Retirement Income Plan or the Phillips Pension Plan, you had the option of electing retiree medical coverage in lieu of COBRA beginning at the time of layoff or at the end of the 18 months of COBRA continuation coverage. For either retiree medical or COBRA coverage, you paid active employee contribution rates for the first six months of coverage.
Special Separation Program: April 3, 1986 through June 30, 1986	If you were an employee born in 1936 or earlier and you were eligible for retiree medical coverage, you had the option of electing retiree medical coverage in lieu of COBRA beginning at the time of layoff or at the end of the 18 months of COBRA continuation coverage. For either retiree medical or COBRA coverage, you paid active employee contribution rates for the first six months of coverage.
1988 Special Layoff Program: Jan. 5, 1988 through June 30, 1988	If you were age 50 – 54 in the calendar year of your termination date, you had the option of electing retiree medical coverage in lieu of COBRA beginning at the time of layoff or at the end of the 18 months of COBRA continuation coverage. For either retiree medical or COBRA coverage, you paid active employee contribution rates for the first six months of coverage.
1988 Enhanced Layoff Program: Oct. 1, 1988 through March 31, 1989	If you were age 50 – 54 in the calendar year of your termination date, you had the option of electing retiree medical coverage in lieu of COBRA beginning at the time of layoff or at the end of the 18 months of COBRA continuation coverage. For either retiree medical or COBRA coverage, you paid active employee contribution rates for the first six months of coverage.
1989 Enhanced Layoff Program: March 15, 1989 through July 31, 1989	If you were age 50 – 54 in the calendar year of your termination date, you had the option of electing retiree medical coverage in lieu of COBRA beginning at the time of layoff or at the end of the 18 months of COBRA continuation coverage. For either retiree medical or COBRA coverage, you paid active employee contribution rates for the first six months of coverage.
1991 Enhanced Supplemental Layoff Program: Nov. 11, 1991 through Dec. 31, 1999	If you were age 50 – 54 in the calendar year of your termination date, you had the option of electing retiree medical coverage in lieu of COBRA beginning at the time of layoff or at the end of the 18 months of COBRA continuation coverage. For either retiree medical or COBRA coverage, you paid active employee contribution rates for the first six months of coverage.

(continued)

If You Were Laid Off on this Date (by Layoff or Sale):	You Have/Had this Medical Coverage Available to You:
Oct. 23, 1993: Phillips Fibers Corporation sold to Amoco Fabrics and Fibers Company	Your Company medical and dental coverage continued until the end of the month of the effective date of the sale. Then, if you were age 55 or older at the time of the sale, you were eligible to enroll in retiree medical coverage anytime during the one-year period following the sale. Prior to Jan. 1, 2009, you could elect to continue your frozen premiums in the Traditional medical option and not have creditable prescription drug coverage under Original Medicare Part D prescription drug coverage (prescription drug retail discount card **only**). If you changed your enrollment to a non-frozen premium, you could have retail and mail-order creditable prescription drug coverage and could no longer elect the frozen premium coverage provision. Effective Jan. 1, 2009, you are eligible only for coverage under the Retiree Medical Age 65 and Over Plan, with an increased Company contribution to compensate for the past frozen premium level. The prescription drug retail discount card was discontinued on Jan. 1, 2009. Any disabled eligible dependent with a frozen premium in the Traditional medical option of the Retiree Medical Pre-Age 65 Plan on Dec. 31, 2008 can remain in this option until they reach age 65. In lieu of the prescription drug retail discount card, disabled eligible dependents may receive covered prescription drugs through the Traditional option by paying 100% of the company's contracted rate.
Phillips Retail Medical Plan — all participants: April 1, 1996 through Dec. 31, 2001	If you were age 50 – 54 in the calendar year of your termination date, you had the option of electing retiree medical coverage in lieu of COBRA beginning at the time of layoff (if you were enrolled in medical coverage) or at the end of the 18 months of COBRA continuation coverage.
Laid off after Jan. 1, 2000 and before March 11, 2002	If you were age 50 – 54 in the calendar year of your termination date, you had the option of electing retiree medical coverage in lieu of COBRA beginning at the time of layoff (if you were enrolled in medical coverage) or at the end of the 18 months of COBRA continuation coverage. For either retiree medical or COBRA coverage, you paid active employee contribution rates for the first six months of coverage.
Under the Work Force Stabilization Plan: March 12, 2002 through March 12, 2004	If you were age 50 or older during the calendar year of your termination date, you were eligible to continue medical coverage either by electing retiree medical or COBRA continuation coverage.

Cost Sharing

Effective on this Date:	The Following Changes Were Made to the Retiree Medical Cost-Sharing Provisions:
Jan. 1, 2016	Participants (includes retirees and their eligible dependents) who have coverage under the Retiree Medical Age 65 and Over Plan on Dec. 31, 2015 will continue to be eligible to receive Company premium cost-sharing contributions until Dec. 31, 2025, per provisions in effect on Dec. 31, 2015; however, premium cost-sharing contributions will be phased out over a ten-year period with the contributions ending Dec. 31, 2025. This includes participants who were a ConocoPhillips employee eligible for retiree medical because their employment ended due to approval for long-term disability (LTD) benefits on Jan. 1, 2007 or after, and an eligible surviving spouse/domestic partner or dependent of any participant. New participants in the Retiree Medical Age 65 and Over Plan on Jan. 1, 2016 and after pay 100% of the Plan premium. Effective Jan. 1, 2021, the Company premium cost-sharing contribution will not be reinstated if you voluntarily terminate your Plan coverage for any reason other than being rehired by the Company. If coverage for you or your eligible dependent(s) for this Plan is terminated due to non-payment, the Company premium cost-sharing contribution will only be reinstated if you pay all back premiums subject to the Claims Administrator's procedures. Effective Jan. 1, 2019, the premium cost-sharing contribution was reinstated one time only if you had become subject to a premium cost share for the first time as a result of the contribution phase out. Effective Jan. 1, 2016, the contribution was not reinstated for any reason other than being rehired by the Company. A rehired retiree and any eligible dependents (who were eligible for the Company premium cost-sharing contribution and covered by the Plan on Dec. 31, 2015) may subsequently re-enroll in the Plan after termination of employment and receive the Company premium cost-sharing contribution, if still available. If the Company contribution is terminated for only the retiree/surviving dependent/long-term disability participant, it can be continued for any of the participant's eligible dependents as long as their individual coverage is not terminated. Retirees who were born prior to Mar. 1, 1921 or retirees of Phillips Fibers Corporation who were laid off in connection with the Oct. 23, 1993 sale to Amoco Fabrics and Fibers Company and, in each case, their respective dependents are not subject to this change.
Jan. 1, 2012	For all retirees, regardless of termination date, the 4.5% cap was modified for those in the Pre-65 medical options.
Jan. 1, 2009	For all retirees, regardless of termination date, the 4.5% cap was modified for those in the Retiree Medical Age 65 and Over Plan. The frozen premium option was eliminated for retirees who elected the frozen premium option under the Traditional medical option without retail prescription drug coverage (retirees were eligible if they were born prior to March 1, 1921 or retired from Phillips Fibers Corporation). Coverage is available only under the Retiree Medical Age 65 and Over Plan.
Jan. 1, 2009	For retirees age 65 and over whose termination date was prior to Jan. 1, 2005, the various heritage Phillips retiree medical rates were harmonized by converting them to a new retiree rate band.
Jan. 1, 2007	For retirees under age 65 whose termination date was prior to Jan. 1, 2005, the various heritage Phillips retiree medical rates were harmonized by converting them to a new retiree rate band.
Jan. 1, 2005	Heritage Phillips retirees whose termination date was on or after Jan. 1, 2005 are considered ConocoPhillips retirees. These retirees are **not** eligible for the heritage Phillips retiree rate band.
Jan. 1, 2003	For heritage Phillips retirees whose termination date was prior to Jan. 1, 2005, a 4.5% cap was implemented on annual increases of Company contributions for retiree medical. Retirees who were eligible for frozen premiums under the Traditional medical option without retail prescription drug coverage (retirees who were born prior to March 1, 1921 or retired from Phillips Fibers Corporation) are not subject to the 4.5% cap.
Prior to Jan. 1, 2003	The Company paid 50% of the medical premium for pre-Medicare coverage. For retirees on Original Medicare, the Company paid 50% of the premium for the mail order prescription drug benefit (no retail prescription benefit was available), and retirees paid 100% of the premium for medical coverage.

Retiree Medical Rate Band

The following rate band applies if your cost sharing method is not based on the 65-point rule:

Band	Heritage Phillips Retirees	Percent of Maximum Company Contribution
80	All participants	90%

"What the Plan Costs," page B-14 (Retiree Medical – Pre-Age 65); "What the Plan Costs," page C-8 (Retiree Medical – Age 65 and Over)

Dental

If you and your eligible dependents are eligible for retiree medical coverage, you and your eligible dependents are also eligible for retiree dental coverage. You pay 100% of the Retiree Dental premium as of Jan. 1, 2008.

Heritage Tosco

The information in this section applies to you if you were a heritage Tosco individual and your employment ended on or before Dec. 31, 2006.

Eligibility

You're eligible for retiree medical coverage, with retiree medical premiums that have Company contributions, if:

- You were a non-store employee of heritage Tosco; and
- You become eligible for retiree medical coverage while you were:
  - An employee at a heritage Tosco refinery (Alliance, Bayway, Ferndale, Los Angeles, Rodeo, Santa Maria, Trainer or Wood River);
  - An employee in Distribution;
  - An employee as a Marketing truck driver;
  - An employee at any Company facility, and you are eligible for a Tosco Pension Plan benefit; or
  - An employee at the Avon refinery, Ferndale refinery, Concord refinery or Bakersfield 76 terminal who is receiving long-term disability (LTD) benefits, and you had 10 or more years of service when you became disabled while working there or were any other heritage Tosco employee receiving LTD benefits and designated on Company records as eligible for retiree medical. The credited service you receive under the Tosco Pension Plan while you are receiving LTD payments counts toward both the age and service requirements for retiree medical coverage, and you could be eligible for coverage when LTD payments end if you were not eligible on your termination date.

If You Meet the Following Eligibility Requirements:	Your Medical Coverage May be Continued as Follows:
You were a non-store employee age 55 or older and had at least 10 years of service on your termination date.	You may continue medical coverage if you were covered under a Company medical plan (excludes union-sponsored plan). **Note:** Effective Jan. 1, 2005, the requirement that you had to be **enrolled** on your termination date was changed to that you just had to be **eligible** for coverage on that date.
You were laid off effective March 12, 2002 through March 11, 2004 under the Work Force Stabilization Plan.	If you were under age 50 during the calendar year of termination, you were eligible for COBRA continuation coverage for 18 months.
You were laid off effective March 12, 2002, through March 11, 2004 under the Work Force Stabilization Plan.	If you were age 50 or older during the calendar year of your termination date, you were eligible to continue medical coverage either by electing retiree medical or COBRA continuation coverage if: • You retired directly from active service with Tosco (you were not on a leave of absence); • You were covered under a Company medical plan (excludes union-sponsored plans) immediately before you retired; and • You had completed 10 or more years of service and were at least age 55 when you retired.
You were laid off effective between Feb. 1, 2001 and Dec. 31, 2006 and were at least age 50 on your termination date.	You are eligible for retiree medical coverage for you and your covered dependents. **Note:** Effective Jan. 1, 2005, the requirement that you had to be **enrolled** on your termination date was changed to that you just had to be **eligible** for coverage on that date.
You're a surviving spouse/dependent child of a deceased heritage Tosco retiree who died on or after: • Age 55 (if the date of death was before Feb. 1, 2001); or • Age 50 (if the date of death was between Feb. 1, 2001 and Dec. 31, 2006).	**If the retiree's death was before Jan. 1, 2005,** you may continue medical coverage if you were covered under a Company medical plan (excludes union-sponsored plans) at the time of the retiree's death. **If the retiree's death was on or after Jan. 1, 2005,** you may continue or enroll in medical coverage if the retiree was eligible at the time of death (excludes union-sponsored plans) and you enrolled when you were initially eligible.
You're a surviving spouse/dependent child of a deceased heritage Tosco employee who died on or after Jan. 1, 2003 and before Jan. 1, 2007.	**If the employee's death was on or after Jan. 1, 2003 and before Jan. 1, 2005,** you may continue medical coverage if you were covered under a Company medical plan (excludes union-sponsored plans) at the time of the employee's death. **If the employee's death was on or after Jan. 1, 2005 and before Jan. 1, 2007,** you may continue or enroll in medical coverage if you were **eligible** under a Company medical plan (excludes union-sponsored plans) at the time of the employee's death and you enrolled when you were initially eligible.
You're a surviving domestic partner of a deceased heritage Tosco individual who died on or after Jan. 1, 2006 and you and the heritage Tosco individual were covered under a Company medical plan at the time of the retiree's/employee's death.	You may continue medical coverage. **Note:** This provision does not apply to your children.
You were a heritage Tosco employee who became eligible between Jan. 1, 2003 and Dec. 31, 2006 due to approval for long-term disability (LTD) benefits (or you would have been approved if you had been enrolled in the plan).	You are eligible to enroll in retiree medical coverage when you terminate your employment. You will be considered heritage Conoco for cost-sharing provisions.

Cost Sharing

The following rules apply to cost sharing under the Medical Plan for heritage Tosco individuals:

- Retiree medical coverage is 100% paid by the Company and is not subject to any Company contribution cap for heritage Tosco El Dorado union-represented retirees.
- Retiree medical coverage had various levels of Company contributions for only the following:
  - An employee at a heritage Tosco refinery (Alliance, Bayway, Ferndale, Los Angeles, Rodeo, Santa Maria, Trainer or Wood River);
  - An employee in Distribution;
  - An employee as a Marketing truck driver;
  - An employee at any Company facility and you are eligible for a Tosco Pension Plan benefit.
- Retiree medical (includes dental) cost-sharing rates are frozen and are not subject to any Company contribution cap for heritage Tosco retired executives who:
  - Were eligible for the ConocoPhillips Senior Executive Retirement Plan (SERP);
  - Were **not** eligible for the ConocoPhillips Retiree Medical and Dental Plan; and
  - Have SERP contracts with a cost-sharing arrangement that is generally equivalent to the amount of the medical payroll deduction in effect at their termination date.
- Heritage Tosco employees who are receiving long-term disability (LTD) benefits and who had 10 or more years of service when they became disabled while working at the Avon refinery, Ferndale refinery, Concord refinery or Bakersfield 76 terminal will pay the current employee contribution rates until they turn age 65. After age 65, they'll:
  - Be eligible for medical coverage through either COBRA or retiree medical if they meet the eligibility requirements on page I-14 for retiree medical; and
  - Will pay the corresponding rates for coverage.

Effective on This Date:	The Following Changes Were Made to the Retiree Cost-Sharing Provisions:
Jan. 1, 2016	Participants (includes retirees and their eligible dependents) who have coverage under the Retiree Medical Age 65 and Over Plan on Dec. 31, 2015 will continue to be eligible to receive Company premium cost-sharing contributions until Dec. 31, 2025, per provisions in effect on Dec. 31, 2015; however, premium cost-sharing contributions will be phased out over a ten-year period with the contributions ending Dec. 31, 2025. This includes participants who were a ConocoPhillips employee eligible for retiree medical because their employment ended due to approval for long-term disability (LTD) benefits on Jan. 1, 2007 or after, and an eligible surviving spouse/domestic partner or dependent of any participant. New participants in the Retiree Medical Age 65 and Over Plan on Jan. 1, 2016 and after pay 100% of the Plan premium. Effective Jan. 1, 2021, the Company premium cost-sharing contribution will not be reinstated if you voluntarily terminate your Plan coverage for any reason other than being rehired by the Company. If coverage for you or your eligible dependent(s) for this Plan is terminated due to non-payment, the Company premium cost-sharing contribution will only be reinstated if you pay all back premiums subject to the Claims Administrator's procedures. Effective Jan. 1, 2019, the premium cost-sharing contribution was reinstated one time only if you had become subject to a premium cost share for the first time as a result of the contribution phase out. Effective Jan. 1, 2016, the contribution was not reinstated for any reason other than being rehired by the Company. A rehired retiree and any eligible dependents (who were eligible for the Company premium cost-sharing contribution and covered by the Plan on Dec. 31, 2015) may subsequently re-enroll in the Plan after termination of employment and receive the Company premium cost-sharing contribution, if still available. If the Company contribution is terminated for only the retiree/surviving dependent/long-term disability participant, it can be continued for any of the participant's eligible dependents as long as their individual coverage is not terminated. Retirees of heritage Tosco El Dorado union-represented retirees and heritage Tosco retired executives are not subject to this change.
Jan. 1, 2012	For all retirees, regardless of termination date, the 4.5% cap was modified for those in the Pre-65 medical options.
Jan. 1, 2009	For all retirees, regardless of termination date, the 4.5% cap was modified for those in the Retiree Medical Age 65 and Over Plan.

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Jan. 1, 2009	For retirees age 65 and over with retiree medical premiums that have Company contributions whose termination date was prior to Jan. 1, 2007, the various heritage Tosco retiree medical rates were harmonized by converting them to new retiree rate bands. This changed maintained or increased the previous heritage Tosco cost sharing.
Jan. 1, 2007	Heritage Tosco retirees whose termination date was on or after Jan. 1, 2007 are considered ConocoPhillips retirees. These retirees are **not** eligible for the heritage Tosco retiree rate bands.
Jan. 1, 2007	For retirees under age 65 with retiree medical premiums that have Company contributions whose termination date was prior to Jan. 1, 2007, the various heritage Tosco retiree medical rates were harmonized by converting them to new retiree rate bands. This change maintained or increased the previous heritage Tosco cost sharing.
Jan. 1, 2006	The additional 2% administration fee required of retirees with medical coverage, without a Company contribution, was eliminated.
Jan. 1, 2003	For heritage Tosco retirees whose termination date was prior to Jan. 1, 2007, a 4.5% cap was implemented on annual increases of Company contributions for retiree medical. Retirees not eligible for retiree medical premiums with Company contributions pay 102% of the premium.
Prior to Jan. 1, 1997	Retirees who were eligible for retiree medical premiums with Company contributions had a fixed cost-sharing amount that was not based on age and service.

Retiree Medical Rate Bands

The following rate bands apply if your cost sharing method is not based on the 65-point rule:

Bands	Sum of the Retiree's Age and Service on Termination Date	Percent of Maximum Company Contribution
02	No Company contribution	0%
70	95 or more points, or retired prior to Jan. 1, 1997	70%
65	65 to 94 points	60%

"What the Plan Costs," page B-14 (Retiree Medical – Pre-Age 65); "What the Plan Costs," page C-8 (Retiree Medical – Age 65 and Over)

Dental

If you and your eligible dependents are eligible for retiree medical coverage, you and your eligible dependents are eligible for retiree dental coverage. You pay 100% of the Retiree Dental premium as of Jan. 1, 2008. Heritage Tosco retirees under a Senior Executive Retirement Plan have frozen cost-sharing rates.

No Heritage Company

The information in this section applies to you if:

- You were not an employee of a heritage company;
- You were hired on or after Jan. 1, 2003; and
- Your employment ended on or before Jan. 1, 2007.

If you're eligible for retiree benefits or have surviving dependents who become eligible for retiree benefits, you'll be considered heritage Conoco for the medical and dental cost-sharing provisions.

"Who Is Eligible," page B-5 (Retiree Medical – Pre-Age 65); "Who Is Eligible," page C-3 (Retiree Medical – Age 65 and Over)

Phillips 66 Retirees

If you transferred to a member of the Phillips 66 controlled group on April 30, 2012 in connection with the distribution of Phillips 66 shares to the shareholders of ConocoPhillips and were enrolled in one or more of the ConocoPhillips retiree plans (Retiree Medical Under Age 65, Retiree Medical Age 65 and Over, Retiree Dental) on July 1, 2015, you and your eligible dependents will retain eligibility per the 65-point rule provisions as of April 30, 2012 (age 50 years of age, 10 completed years of service and a minimum of 65 age and service points). If you were not enrolled on July 1, 2015, your status will change to that of an ineligible Phillips 66 retiree and you and your eligible dependents will no longer be eligible for the aforementioned three ConocoPhillips retiree plans. These provisions also apply to any surviving dependents of the ineligible Phillips 66 retiree. If an ineligible Phillips 66 retiree later becomes eligible for the ConocoPhillips retiree plans due to being hired by ConocoPhillips, he/she will no longer be considered an ineligible Phillips 66 retiree.

COG Operating LLC Employees

If you were an employee of COG Operating LLC on Jan. 15, 2021 when COG was acquired by ConocoPhillips, you became a ConocoPhillips employee on Jan. 1, 2022; however, you were not eligible for retiree medical and dental insurance. On Jan. 1, 2023, your years of service at COG Operating LLC were added to the ConocoPhillips years of service to determine the points accrued under the 65-point rule for retiree medical and dental insurance eligibility. **Note:** COG Operating LLC also known as Concho Resources.

Shell Enterprises LLC Employees

If you were a former Shell Enterprises LLC employee who transferred to ConocoPhillips with the Permian assets and had been hired by Shell on or after Jan. 1, 2018, the years of service at Shell will be added to the ConocoPhillips years of service on Dec. 1, 2023 to determine the points accrued under the 65-point rule. If instead, you were the transferred employee who was hired by Shell prior to Jan. 1, 2018, your years of service at Shell were added to the ConocoPhillips years of service upon transfer to ConocoPhillips to determine the points accrued under the 65-point rule for retiree medical and dental insurance eligibility.

All Heritage Company and ConocoPhillips Retirees as of Dec. 31, 2015

Participants (includes retirees and their eligible dependents) who have coverage under the Retiree Medical Age 65 and Over Plan on Dec. 31, 2015 will continue to be eligible to receive Company premium cost-sharing contributions until Dec. 31, 2025, per the following provisions in effect on Dec. 31, 2015; however, premium cost-sharing contributions will be phased out over a ten-year period with the contributions ending Dec. 31, 2025. This includes participants who were a ConocoPhillips employee eligible for retiree medical because their employment ended due to approval for long-term disability (LTD) benefits on Jan. 1, 2007 or after, and an eligible surviving spouse/domestic partner or dependent of any participant. New participants in the Retiree Medical Age 65 and Over Plan on Jan. 1, 2016 and after pay 100% of the Plan premium.

Effective Jan. 1, 2021, the Company premium cost-sharing contribution will not be reinstated if you voluntarily terminate your Plan coverage for any reason other than being rehired by the Company. If coverage for you or your eligible dependent(s) for this Plan is terminated due to non-payment, the Company premium cost-sharing contribution will only be reinstated if you pay all back premiums subject to the Claims Administrator's procedures. Effective Jan. 1, 2019, the premium cost-sharing contribution was reinstated one time only if you had become subject to a premium cost share for the first time as a result of the contribution phase out. Effective Jan. 1, 2016, the contribution was not reinstated for any reason other than being rehired by the Company. A rehired retiree and any eligible dependents (who were eligible for the Company premium cost-sharing contribution and covered by the Plan on Dec. 31, 2015) may subsequently re-enroll in the Plan after termination of employment and receive the Company premium cost-sharing contribution, if still available. If the Company contribution is terminated for only the retiree/surviving dependent/long-term disability participant, it can be continued for any of the participant's eligible dependents as long as their individual coverage is not terminated.

Heritage Phillips retirees who were born prior to March 1, 1921, retirees of Phillips Fibers Corporation who were laid off in connection with the Oct. 23, 1993 sale to Amoco Fabrics and Fibers Company, heritage Burlington Resources Pre-1986 El Paso retirees, heritage Burlington Resources Pre-1986 Louisiana Land & Exploration retirees, heritage Tosco El Dorado union-represented retirees and heritage Tosco retired executives and, in each case, their respective dependents are not subject to this change.

All Heritage Company and ConocoPhillips Retirees as of Dec. 31, 2020

Effective Jan. 1, 2021, the Retiree Medical Age 65 and Over Plan changed from Original Medicare Supplement insurance to UnitedHealthcare® Group Medicare Advantage (PPO) insurance. Plan participants enrolled as of Dec. 31, 2020, were automatically enrolled in the ConocoPhillips Core option but could enroll in the ConocoPhillips Plus option or cancel the enrollment effective Jan. 1, 2021. If you later cancelled your enrollment, you could re-enroll in a Plan option during annual enrollment with coverage effective the following Jan. 1. You could also change your enrollment to a different Plan option during annual enrollment with coverage effective the following Jan. 1.

All Heritage Company and ConocoPhillips Retirees Under Age 65 and on Original Medicare as of Dec. 31, 2021

Effective Jan. 1, 2022, the Traditional option of the Retiree Medical Pre-Age 65 Plan was terminated, and participants enrolled as of Dec. 31, 2021, were automatically enrolled in the UnitedHealthcare® Group Medicare Advantage (PPO) of the Retiree Medical Age 65 and Over Plan.

Appendix II — Grandfathered Retiree Life Insurance Benefit Provisions

J

Introduction

The following information provides specific benefit provisions that differ from the Retiree Life Insurance Plan provisions described in this handbook. It applies to participants who retired before Jan. 1, 2003 (or before Jan. 1, 2009, if from heritage Burlington Resources). For applicable provision exceptions that may apply to you, find your company name and your termination date.

"Heritage Burlington Resources Inc. — Employment Ended on or Before Dec. 31, 2008," page J-3; "Heritage Conoco — Employment Ended on or Before Dec. 31, 2002," page J-4; "Heritage Phillips — Employment Ended on or Before Dec. 31, 2002," page J-5; "Heritage Tosco — Employment Ended on or Before Dec. 31, 2002," page J-14

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

"Glossary," page H-1

✔ Benefit plan names in this Appendix reflect name on effective date and not subsequent plan name changes.

✔ Efforts have been made to record historical Plan provisions for retiree life insurance. Contact the Benefits Center if you have documentation for retiree life insurance that is different from, or not included in, the following information.

"Contacts," page A-1

Heritage Burlington Resources Inc. — Employment Ended on or Before Dec. 31, 2008

Termination Date	Coverage Available
Heritage Burlington Resources Inc. retiree April 1, 2008 through Dec. 31, 2008	You were provided Company-paid Basic Retiree Life Insurance in the amount of $10,000 if: • You remained in continuous employment with Burlington Resources Inc. or one of its subsidiaries from March 31, 2006 through March 31, 2007; • You retired after March 31, 2007 but prior to Jan. 1, 2009; and • You didn't meet the ConocoPhillips retiree life insurance eligibility, but **did** meet the heritage Burlington Resources Inc. retiree life insurance eligibility criteria (qualified for early or normal retirement benefits from the Burlington Resources Inc. Pension Plan (reached age 55 with 10 years of service under the Pension Plan), and you had the Burlington Resources Inc. Basic Life coverage in effect on your termination date). If you met both the ConocoPhillips and the heritage Burlington Resources Inc. retiree life insurance eligibility criteria, and you had Burlington Resources Inc. Basic Life coverage in effect on your termination date, you were eligible to elect either the ConocoPhillips or heritage Burlington Resources Inc. retiree life insurance benefits. The company you elect will be the one used to determine your retiree medical, dental and life insurance provisions. *"Retiree Life Plan," page F-1*
Heritage Burlington Resources Inc. retiree Prior to April 1, 2008	You were provided Company-paid Basic Retiree Life Insurance in the amount of $10,000 if: • You qualified for early or normal retirement benefits from the Burlington Resources Inc. Pension Plan (reached age 55 with 10 years of service under the Pension Plan); and • You had the Burlington Resources Inc. Basic Life coverage in effect on your termination date.
Heritage Burlington Resources Inexco retiree Jan. 1, 1986 and after	Designated Inexco retirees were provided with grandfathered Company-paid life insurance amounts as recorded on Company Plan-approval documents.
Heritage Burlington Resources Pre-1986 El Paso retiree Dec. 31, 1984 and after	If you qualified for early or normal retirement benefits from the Burlington Resources Inc. Pension Plan (reached age 55 with 10 years of service under the Pension Plan), you were provided the greater of: • Company-paid Basic Retiree Life Insurance in the amount of $10,000 if you had the Burlington Resources Inc. Basic Life coverage in effect on your termination date; or • A special post-retirement death benefit from the Pension Plan equal to one-half of your annual base salary in effect on Dec. 31, 1984, reduced by 1/15th for each year of service under 15. (For example, 13 years of service would pay an amount equal to one-half of the annual base salary multiplied by 13/15ths.) Your beneficiary will receive only the greater of the above two benefits. Both benefits will not be paid.
Heritage Burlington Resources Post-1986 Louisiana Land & Exploration (LL&E) retiree Prior to Jan. 1, 2000	No retiree life insurance was available unless you're a heritage Burlington Resources Inexco retiree.

Heritage Conoco — Employment Ended on or Before Dec. 31, 2002

Note: This section doesn't apply to you if you were affected by any of the following events:

- Sale of Conoco Chemicals to VISTA on July 20, 1984.
- Sale of Conoco Alaska interests to BP on Jan. 1, 1994.
- Chocolate Bayou Plant acquired by Conoco Aug. 21, 1981, acquired by DuPont on Jan. 1, 1984 and sold to Cain Chemical on June 8, 1987.
- Outsourcing of computer services May 31, 1987 to Aug. 31, 1997.

Retirees affected by these events don't have retiree life insurance from ConocoPhillips; they may have coverage through their other company.

Note: In 1985, an Early Retirement Opportunity (ERO) program added five years to service and age for retirement plan eligibility. If the increased age and service resulted in an employee being eligible for Early or Normal retirement, they were eligible for retiree life insurance. Coverage amount and cost were based on actual age, not ERO age.

ERO did not apply to eligibility for Incapacity Retirement.

Termination Date	Coverage Available
Prior to Jan. 1, 1983, and you were age 62	You were provided with $5,000 of Company-provided life insurance coverage.
Prior to Jan. 1, 1983, and you retired with an incapacity retirement	You were provided with $2,000 of Company-provided life insurance coverage.
Jan. 1, 1983 through Dec. 31, 2002, and you were age 50 – 64 on your termination date	You can continue coverage up to the amount of coverage in force on the day prior to your termination date. You can retain this coverage until you reach age 65. The Company pays for the first $10,000 of coverage; you pay for the remainder at the age-based rates. Coverage is rounded to the next-higher thousand dollars.
Jan. 1, 1983 through Dec. 31, 2002, and you are age 65 or older	You have Company-provided life insurance coverage as follows: • If you're age 65 – 67: $10,000 coverage • If you're age 68 – 69: $ 7,000 coverage • If you're age 70 and over: $ 5,000 coverage The Company pays for this coverage, which reduces per your age until you reach age 70. You aren't eligible for any additional coverage.
Jan. 1, 1983 through Dec. 31, 2002, and you retired with an incapacity retirement	You can continue coverage up to the amount of coverage in force on the day prior to your termination date. You can retain this coverage until you reach age 65. The Company pays for the same amount of basic coverage you had as an active employee, and you pay for the remainder at the age-based rates. Coverage is rounded to the next-higher thousand dollars. When you reach age 65, your coverage automatically converts to the schedule shown under "Jan. 1, 1983 through Dec. 31, 2002, and you are age 65 or older" above.
Prior to 1972 Agrico sale	If you retired from Agrico prior to their sale in 1972, you were provided with $3,000 of Company-provided life insurance coverage.
Prior to Jan. 1, 2003, and you were a store employee	You were eligible for retiree life insurance if you were a store employee who met the benefit requirements under the Retirement Plan of Conoco (had reached age 50 with 10 years of service on your termination date).

Heritage Phillips — Employment Ended on or Before Dec. 31, 2002

The following is a very brief overview of how the amount of retiree insurance was determined for most eligible retirees. The official provisions and conditions in effect at the time you retired will apply. **Note:** Different provisions apply for Retail Marketing (store) retirees, recipients of long-term disability (LTD) benefits and laid off retirees.

"Retail Marketing (Store) Employees," page J-7; "Recipients of Long-Term Disability Benefits," page J-8; "Laid Off Employees Age 50 Through 54," page J-9; "Laid Off Employees Due to Asset Sale/Acquisition/Joint Venture," page J-10

Note: The information in this section doesn't apply to all heritage Phillips retirees.

"Heritage Phillips Retiree Life Insurance Exceptions," page J-13

Termination Date	Coverage Available
Jan. 1, 1961 through Aug. 31, 1968 **Note:** You were **not** eligible for non-contributory retiree life insurance coverage if: • You were hired as a regular full-time employee Jan. 1, 1961 through March 1, 1974; and • You were age 50 or older when you started working for Phillips.	You received $1,000 life insurance coverage (at no cost to you) effective your first day of retirement if you retired at age 65, provided that on that date: • You were **not** participating in the Retirement Income Plan; or • You **were** participating in the Retirement Income Plan as it was prior to the Nov. 1, 1955 revision. You received $2,000 life insurance coverage (at no cost to you) effective the first day of your retirement if you retired and were participating in the Retirement Income Plan as revised on Nov. 1, 1955. **Note:** The Company reimbursed you for medical and hospital expenses incurred, up to one-half the amount of the life insurance in force (maximum $1,000), if you: • Were in the Retirement Income Plan as revised on Nov. 1, 1955 following retirement; and • Had been carrying Comprehensive Medical Insurance (now called the Traditional option) prior to retirement but decided not to carry Comprehensive Medical Insurance during retirement. These interest-free advancements of medical and hospital expenses were deducted from the face amount of life insurance paid, but were discontinued on Sept. 1, 1968.
Sept. 1, 1968 through Feb. 1, 1981 **Note:** You were **not** eligible for non-contributory retiree life insurance coverage if: • You were hired as a regular full-time employee Jan. 1, 1961 through March 1, 1974; and • You were age 50 or older when you started working for Phillips.	Your $2,000 non-contributory coverage continued after retirement if: • You were not participating in the basic contributory coverage as an employee; and • You had not received total and permanent disability payments. If you **were** participating in the basic contributory life insurance plan as an employee and you haven't received total and permanent disability payments, your life insurance coverage amount continued as follows: • One-half of your basic contributory coverage amount and one-half of your non-contributory coverage amount in effect prior to retirement continued, subject to a maximum of $50,000. • Each year, your coverage decreased by 10% of the original amount until it reached the minimum non-contributory coverage amount of 30% of your original retiree coverage amount or $4,000 (whichever is greater).

(continued)

Termination Date	Coverage Available
Jan. 1, 1981 through Dec. 31, 1987	Your $2,000 non-contributory coverage continued after retirement if: • You were not participating in the basic contributory coverage as an employee; and • You had not received total and permanent disability payments. If you **were** participating in the basic contributory life insurance plan as an employee during the month before your retirement, life insurance coverage equal to one times your annual pay continued as follows: • Annual pay is based on your salary on the day before you retired and is rounded to the next-higher multiple of $100, if not already a multiple of $100. • Each year on the anniversary of your retirement, your coverage decreased by 10% of the original amount until it reached the minimum non-contributory coverage amount of 30% of your original retiree coverage amount or $4,000 (whichever is greater).
Jan. 1, 1988 through Dec. 31, 1995	Your $2,000 non-contributory coverage continued after retirement if: • You were not participating in the basic contributory coverage as an employee; and • You had not received total and permanent disability payments. If you **were** participating in the basic contributory life insurance plan as an employee during the month before your retirement, life insurance coverage equal to one times your annual pay continued as follows: • Annual pay is based on your salary on the day before you retired and is rounded to the next-higher multiple of $100, if not already a multiple of $100. • Each year on the anniversary of your retirement, your coverage decreased by 10% of the original amount until it reached the minimum non-contributory coverage amount of $10,000.
Jan. 1, 1996 through Dec. 31, 2002	If you were **not** enrolled in basic life insurance on the date you retired, you have no retiree coverage. Non-contributory life insurance was not available. If you **were** enrolled in basic life insurance on the date you retired, life insurance coverage equal to one times annual pay continued as follows: • Annual pay is based on your salary as of Jan. 1 of the year in which you retired. • Each year on the anniversary of your retirement, your coverage decreased by 10% of the original amount until it reached the minimum non-contributory coverage amount of $10,000. • If you retired after your normal retirement date, your retiree life coverage took effect as though you had retired on your normal retirement date. **For example,** if you retired at age 67, your retiree life coverage was 80% of your annual pay at the time you reached age 65. • In order to be eligible for retiree life insurance coverage, you must have had at least 10 consecutive years of service and have reached age 55 before retiring. • If you were laid off (as determined under the Phillips Layoff Plan) at any time during or after the calendar year in which your 50th birthday occurred, you're considered a retiree for life insurance and the 10-year service requirement does not apply.

Retail Marketing (Store) Employees

The following information applies to Retail Marketing (store) employees only.

Termination Date	Coverage Available
Prior to April 1, 1996	Amounts as recorded on Company life insurance records.
April 1, 1996 through Dec. 31, 2001	You must have had at least 10 consecutive years of service and have reached age 55 before retiring in order to be eligible for retiree life insurance coverage. If you were laid off (as determined under the Phillips Layoff Plan) at any time during or after the calendar year in which your 50th birthday occurs, you were considered a retiree for life insurance, and the 10-year service requirement didn't apply. **Store Managers and Manager Trainees (Assistant Manager Through Dec. 31, 1999):** If you retired **on or before the normal retirement date** (age 65), your coverage was equal to basic coverage (one times annual pay). Each year on the anniversary of retirement, your coverage decreases by 10% of the original amount until it reached $10,000. If you retire **after the normal retirement date** (after age 65), your retiree life insurance coverage took effect as though you had retired on your normal retirement date. **Store Managers and Manager Trainees (starting Jan. 1, 2000)** were eligible for the Phillips employee/retiree life insurance provisions (as described in the last row of the table on page J-6). **Non-Managerial Employees (Assistant Manager) (starting Jan. 1, 2000), Senior Assistant Manager (Starting Jan. 1, 2000), Metro Trainer Recruiter, Service Specialist and Customer Service Associate):** Your retiree life insurance coverage amount is $10,000 (does not reduce). **NOTE:** Annual pay used to determine life insurance amount includes commissions for retail employees.
Jan. 1, 2002 and after	Retiree life insurance benefits were not available unless you were age 55 or older and eligible for retiree life insurance benefits on Dec. 31, 2001 (as described in the row above). If you were eligible, retiree life insurance was provided as described in the row above.

Recipients of Long-Term Disability Benefits

The following information applies to recipients of long-term disability (LTD) benefits only. Your retiree life insurance coverage will be based on the grandfathered provision in effect at the time your LTD benefits began. If your LTD benefits end and you are not eligible for Company-paid retiree life insurance, your life insurance will be terminated when your LTD benefit ends.

Termination Date	Coverage Available
Oct. 1, 1969 through Dec. 31, 1987 **Note:** You're **not** eligible for non-contributory retiree life insurance coverage if: • You were hired as a regular full-time employee Jan. 1, 1961 through March 1, 1974; and • You were age 50 or older when you started working for Phillips.	Your $2,000 non-contributory coverage continued after retirement if: • You were not participating in the basic contributory coverage as an employee; and • You had not received total and permanent disability payments. If you **were** participating in the contributory life insurance plan as an employee and you had not received total and permanent disability payments, your life insurance coverage amount continued as follows: • One-half of your basic contributory coverage amount and one-half of your non-contributory coverage amount in effect prior to retirement continued, subject to a maximum of $50,000. • Each year, your coverage decreased by 10% of the original amount until it reached the minimum non-contributory coverage amount of 30% of your original retiree coverage amount or $4,000 (whichever is greater).
Jan. 1, 1988 through Dec., 31, 1995	When LTD benefits begin, you were paid the basic non-contributory life insurance amount (max of $2,000) as a lump sum. When you started receiving LTD insurance benefits, you were also eligible for a life insurance waiver of premium on your contributory coverage until the earlier of the date you begin receiving retirement benefits or your normal retirement date (when you may be covered as a retiree).[1] Retiree non-contributory coverage continued as follows: • Each year on the anniversary of your retirement, your coverage decreased by 10% of the original amount until it reached the minimum non-contributory coverage amount of $10,000. If you don't become a retired employee, the disability premium waiver and your coverage end on your normal retirement date.
Jan. 1, 1996 through Dec. 31, 2002	The following life insurance provisions were grandfathered at retirement for you if: • You began LTD benefits and terminated prior to Jan. 1, 2003 (or, if you're a Puerto Rico Core employee, you started receiving LTD benefits prior to July 1, 2000 and so did not transfer to ChevronPhillips Chemical Company); and • You had the disability premium waiver. You received Company-paid life insurance coverage equal to one times your annual pay (rounded to the next $100). • Each year on the anniversary of your retirement, your coverage decreases by 10% of the original amount until it reaches the minimum non-contributory coverage amount of $10,000. • Any amount over one times your annual pay may be converted to an individual policy, provided the appropriate forms are submitted within 31 days after the disability premium waiver ends. • The disability premium waiver will continue until the earlier of the date you begin receiving retirement benefits or your normal retirement date (when you may be covered as a retiree).[1] • If you don't become a retired employee, the disability premium waiver and your coverage end on your normal retirement date.

[1] *An election during the voluntary deferred vested lump-sum cash-out period from July 16, 2014 through Sept. 15, 2014 to receive a distribution of vested accrued benefits from the ConocoPhillips Retirement Plan will not cause the disability premium waiver related to contributory coverage to cease.*

Laid Off Employees Age 50 through 54

The following information applies to you only if you were laid off under one of the situations shown below. Your retiree life insurance coverage will be based on the grandfathered provision in effect at the time you were laid off.

Termination Date Due to Layoff	Coverage Available
Aug. 1, 1982 through April 2, 1986	You were provided retirement-level life insurance if you were: • Age 50 or over on your termination date; • Vested in the Retirement Income Plan or Phillips Pension Plan; and • Enrolled in basic life insurance at the time of termination.
Special Separation Program April 3, 1986 through June 30, 1986	Retiree life insurance was provided to you if you were born in 1936 or earlier (you were age 50 or older in the calendar year of layoff).
1988 Special Layoff Program Jan. 5, 1988 through June 30, 1988	Retiree life insurance was provided to you if you were enrolled in basic life insurance prior to layoff and were age 50 or older in the calendar year of layoff. If you were **not** enrolled in basic life insurance prior to layoff, you were provided with the non-contributory life insurance coverage amount (usually $2,000).
1988 Enhanced Layoff Program Oct. 1, 1988 through March 31, 1989	Retiree life insurance was provided to you if you were enrolled in the basic life insurance prior to layoff and were age 50 or older in the calendar year of layoff. If you were **not** enrolled in the basic life insurance prior to layoff, you were provided with the non-contributory life insurance coverage amount (usually $2,000).
1989 Enhanced Layoff Program March 15, 1989 through July 31, 1989	Retiree life insurance was provided to you if you were enrolled in the basic life insurance prior to layoff and were age 50 or older in the calendar year of layoff. If you were **not** enrolled in the basic life insurance prior to layoff, you were provided with the non-contributory life insurance coverage amount (usually $2,000).
1991 Enhanced Supplemental Layoff Program Nov. 11, 1991 through Dec. 31, 1995	Retiree life insurance was provided to you if you were enrolled in the basic life insurance prior to layoff and were age 50 or older in the calendar year of layoff. If you were **not** enrolled in the basic life insurance prior to layoff, you were provided with the non-contributory life insurance coverage amount (usually $2,000).
1991 Enhanced Supplemental Layoff Program Jan. 1, 1996 through Dec. 31, 1999	Retiree life insurance was provided to you if you were enrolled in the basic life insurance prior to layoff and were age 50 or older in the calendar year of layoff. If you were **not** enrolled in the basic life insurance prior to layoff, you have no retiree life insurance.
Jan. 1, 2000 through Dec. 31, 2002 Enhanced Supplemental Layoff with CEO approval only	Retiree life insurance was provided to you if you were enrolled in the basic life insurance prior to layoff and were age 50 or older in the calendar year of layoff. If you were **not** enrolled in the basic life insurance prior to layoff, you have no retiree life insurance.

Laid Off Employees Due to Asset Sale/Acquisition/Joint Venture

The following information applies to you only if you were laid off under one of the situations shown below. Your retiree life insurance coverage will be based on the grandfathered provision in effect for your particular situation.

Employment Ended Due to Sale/ Acquisition/Joint Venture	Coverage Available
American Fertilizer Sold on Feb. 28, 1986, March 1, 1986 or May 1, 1989	Eligibility for life insurance plan participation ceased upon the sale of the company, but coverage continued until the end of the month of the effective date of the sale. Retiree life insurance was not provided.
Duke Energy Field Services L.L.C. (DEFS) (now DCP Midstream) Joint Venture 2000	You were eligible for retiree life coverage equal to your basic life coverage amount if: • You were age 50 or older in the year of the joint venture; and • Were participating in Basic Group Term Life Insurance; and had less than 10 years of service at the time of the joint venture. Each year, your coverage decreased by 10% of the original amount until it reached the minimum coverage amount of $10,000.
ChevronPhillips Chemicals Joint Venture 2000	If you were a Puerto Rico Core employee who was approved to receive LTD benefits on June 30, 2000, you did not become part of ChevronPhillips Chemicals. As a result, you remained eligible for heritage Phillips retiree life insurance benefits. If you were a Phillips employee on Dec. 31, 2000, and became a ChevronPhillips Chemicals Company employee on Jan. 1, 2001, you had to meet Phillips' retiree life insurance eligibility provisions in effect on Dec. 31, 2000 in order to be eligible for retiree life insurance.[1]
Phillips Fibers Corporation Prior to March 1, 1986	Retiree life insurance is not available.
Phillips Fibers Corporation March 1, 1986 through Dec. 31, 1987 **Note:** A policy separate from Phillips Petroleum existed for Phillips Fibers employees.	**Salaried Employees:** • If you were participating in the contributory life insurance plan as an employee, you were provided with retiree life insurance equal to $4,000 or 30% of your annual pay (whichever is greater) at no cost to you. • If you were **not** participating in the contributory coverage as an employee, you were provided with $4,000 in retiree life insurance at no cost to you. **Hourly Employees:** You were provided with $3,000 in retiree life insurance at no cost to you.
Phillips Fibers Corporation Jan. 1, 1988 through Oct. 22, 1993	For salaried and hourly employees: (a) If you were enrolled in the Phillips Life Insurance Plan, life insurance continued under the same rules as a regular Phillips Petroleum Company employee (because the Phillips Fibers Corporation separate life insurance benefit was terminated on Dec. 31, 1987). (b) If you elected to remain in the Phillips Fibers Corporation Life Insurance Plan, you were provided with retiree life insurance coverage of $4,000 if you were a salaried employee or $3,000 if you were an hourly employee. Coverage was provided at no cost to you. (c) If you were age 55 or older on Oct. 22, 1993, and terminated from the successor employer, Amoco Fabrics and Fiber Company, within the following year, you were eligible for retiree life insurance.

(continued)

[1] *These provisions are described in the table beginning on page J-5 (or in the table beginning on page J-9 if employment ended due to layoff).*

Employment Ended Due to Sale/ Acquisition/Joint Venture	Coverage Available
Phillips Fibers Corporation Oct. 23, 1993 through Oct. 24, 1994	For salaried and hourly employees, eligibility for life insurance plan participation ceased upon the sale of Phillips Fibers Corporation on Oct. 23, 1993. However, coverage continued to the end of the month of the effective date of the sale. Participants who were actively employed, age 55 or older and enrolled in basic life insurance on the date of the sale were eligible for retiree life insurance. These same requirements and provisions were applicable to those who terminated from Amoco Fabrics and Fibers Company prior to Oct. 24, 1994.
Phillips Fibers Corporation If you began receiving long- term disability benefits prior to Jan. 1, 1988	Your life insurance coverage remained with Travelers, and you did not become eligible for Phillips Petroleum Company retiree life insurance provisions.
General American Oil Company If you were a retiree prior to the purchase by Phillips Petroleum Company on Jan. 1, 1983	You have a life insurance amount that has reduced to the minimum of $2,500 (reduced from $50,000 over five years after employment ended).
Tidewater and Lion Oil	Phillips purchased Tidewater from Getty Oil in 1966. On March 31, 1976, Phillips sold Tidewater to Lion Oil who, on the same day, sold assets to Tosco and GATX. Some employees stayed at Phillips through July 31, 1976 and then retired from Phillips. If you retired from Tidewater prior to 1966, retiree life insurance was not provided. If you retired after the Phillips sale, life insurance was not provided per Tosco and GATX provisions (no retiree life insurance). If you retired while owned by Phillips, you were eligible per the Phillips provisions of retiree life insurance applicable to your situation.[1] (**Administrative Note:** Tidewater & Lion Oil eligible retirees are identified in system with payroll numbers ending in "B" or "E".)
Phillips Driscopipe, Inc.	If you left the Company prior to Jan. 1, 1988, you had life insurance coverage from Travelers. Per those provisions, on each anniversary of your retirement, your coverage decreased by 10% of the original amount until it reached the minimum coverage amount of 30% of your original retiree coverage amount or $4,000 (whichever is greater). If you left the Company on or after Jan. 1, 1988, you were eligible per the Phillips provisions of retiree life insurance applicable to your situation.[1]
International Energy, Ltd.	Adopted Phillips Petroleum Company retiree life insurance provisions on Jan. 1, 1989.[1]
Catalyst Resources, Inc. Sold on March 31, 1994	You were provided with $10,000 retiree life insurance coverage at no cost to you.
American Thermoplastics Corp. Sold on March 31, 2000	You were provided with $5,000 in basic retiree life insurance at no cost to you and given the opportunity to elect additional contributory coverage of two times your annual salary at the time of the sale (including the $5,000 basic coverage), rounded to the next higher $1,000. Your basic and contributory coverage was reduced to 15%, subject to a minimum $750 and a maximum of $15,000.

(continued)

[1] *These provisions are described in the table beginning on page J-5 (or in the table beginning on page J-9 if employment ended due to layoff).*

Employment Ended Due to Sale/ Acquisition/Joint Venture	Coverage Available
Phillips Plastics Recycling Company	You were eligible for Phillips retiree life insurance coverage only if you met the eligibility requirements applicable to your situation.[1] (**Administrative Note:** Phillips Plastics Recycling Company eligible retirees are identified in the system by payroll number "33001.")
Phillips Puerto Rico Core, Inc.	You were eligible for Phillips retiree life insurance coverage only if you met the eligibility requirements applicable to your situation.[1] (**Administrative Note:** Phillips Puerto Rico Core eligible retirees are identified in the system by payroll number "74Y0X.") Employees receiving LTD benefits have life insurance per amounts recorded on Company records.

[1] *These provisions are described in the table beginning on page J-5 (or in the table beginning on page J-9 if employment ended due to layoff).*

Heritage Phillips Retiree Life Insurance Exceptions

The information in this "Heritage Phillips — Employment Ended on or Before Dec. 31, 2002" section (pages J-5 – J-12) may not apply to you if you are or were affected by any of the following event/conditions.

For this event/condition:	The information in this table MAY not apply to you because:
Your employment ends after you reached age 65	The amount of your retiree life insurance is based on your normal retirement date.
You were ever on any kind of disability provided through Phillips	Retiree life insurance may have been available to you in some situations and under certain provisions.
You were involved in a sale of facility or merger with another company, or acquired by a Phillips acquisition	The retiree life insurance terms of the sale, merger or acquisition may prevail over the information in this handbook.
You worked for certain subsidiary companies	Some subsidiaries had different retiree life insurance provisions. Many U.S. subsidiaries adopted the life insurance benefits of Phillips Petroleum Company on Jan. 1, 1988. No change was made to benefits for those who became eligible for retiree life insurance prior to that date.
You were laid off, and were under age 55 at the time of the layoff	Some layoff programs included special retiree life insurance provisions.
You began employment **prior to Jan. 1, 1995** and were age 45 or older at that time	You don't need to have 10 or more years of service in order to qualify for the plan provisions applicable to your situation at termination (listed in this Appendix).
If you began employment — or were rehired — on or after Jan. 1, 1995	Unless you were laid off, you must have 10 years of continuous service in order to qualify for the plan provisions applicable to your situation at termination (listed in this Appendix).
You're a former employee who is receiving LTD benefits	Each month you receive LTD benefits counts toward your age and the 10 years of recognized service requirement.
You were a Seaside Oil or Aminoil employee	If your employment ended prior to Phillips' acquisition of your former company, your retiree life insurance provisions in effect as of the acquisition were maintained.
You were under age 50 on the date you began working for Phillips as a regular full-time employee, and you retired prior to July 1, 1975	You weren't eligible for retiree life insurance.
You had executive life insurance on or after Jan. 1, 1996	From Jan. 1, 1996 through Dec. 31, 2002, your Company-paid retiree life insurance was a combination of term life insurance and an annual flex bonus credit. On Jan. 1, 2003, the flex bonus credit was discontinued and your Company-paid life insurance was an amount that started at one times your annual salary on your termination date. Each year since your termination date, your coverage has decreased by 10% of the original amount, until it reaches the minimum coverage amount of $10,000.
You were a Pipeline Relief Pool driver	You weren't eligible for Company-paid retiree life insurance.
You were a Retail Marketing Company (store) employee	Store benefits were often separate from Phillips Petroleum benefits and changed frequently.

Heritage Tosco — Employment Ended on or Before Dec. 31, 2002

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 LTD benefits, life insurance premiums were waived with the life insurance company, subject to all the terms and provisions of the life insurance policy. The life insurance company will contact you periodically and has the records regarding the amount of your life insurance.

If your life insurance is a provision of your pension plan annuity, the annuity payor has the records regarding the amount of your life insurance.

Termination Date	Coverage Available
Avon Union and Avon Non-Union Prior to Jan. 1, 1978	You were provided with retiree life insurance equal to the amount indicated on the Company's retirement records.
Avon Union and Avon Non-Union Jan. 1, 1978 through April 30, 1979	You were provided with retiree life insurance of $1,000 and optional coverage equal to 50% of the coverage you had prior to your termination date (to a maximum of two times salary). Company-provided plus optional coverage was limited to $50,000.
Avon Union May 1, 1979 through Sale of Assets	• If you had participated in contributory life insurance for at least 10 years as of the day before the date of retirement, you were provided with retiree life insurance equal to the lesser of one times annual base pay or $50,000. • If you were **not** participating in the contributory coverage as described above, you were provided with $2,000 in flat-term life insurance. • In either situation above, your coverage was/will be reduced by 50% on the day you reached age 70.
Avon Non-Union May 1, 1979 through Dec. 31, 1984	• If you had participated in contributory life insurance for at least 10 years as of the day before the date of retirement, you were provided with retiree life insurance equal to the lesser of one times annual base pay or $50,000. • If you were **not** participating in the contributory coverage as described above, you were provided with $2,000 in flat-term life insurance. • In either situation above, your coverage was/will be reduced by 50% on the day you reached age 70.
Avon Non-Union Jan. 1, 1985 through Sale of Assets	You were provided with retiree life insurance coverage equal to the lesser of one times annual salary or $50,000. Each year, your coverage was reduced by 20% of the original amount until it reached $5,000.
Bakersfield Union Prior to Feb. 1, 1977	You were provided with $2,500 term life insurance coverage.
Bakersfield Union Feb. 1, 1977 through Dec. 31, 1984	You were provided with $1,500 or $4,000 in term life insurance coverage, as determined according to the benefit election you made under the company retirement plan.
Bakersfield Union Jan. 1, 1985 through Sale of Assets	You were provided with retiree life insurance coverage equal to the lesser of one times annual salary or $50,000. Each year, your coverage was reduced by 20% of the original amount until it reached $5,000.
Bakersfield Non-Union Prior to Feb. 1, 1977	You were provided with $2,500 term life insurance coverage.
Bakersfield Non-Union Feb. 1, 1977 through Dec. 31, 1984	You were provided with $4,000 term life insurance coverage.

(continued)

Termination Date	Coverage Available
Bakersfield Non-Union Jan. 1, 1985 through Sale of Assets	You were provided with retiree life insurance coverage equal to the lesser of one times annual salary or $50,000. Each year, your coverage was reduced by 20% of the original amount until it reached $5,000.
Duncan Union & Non-Union July 1, 1984 through Dec. 31, 1984	You were provided with retiree life insurance coverage equal to one times annual salary. Starting at age 66, your coverage was/will be reduced by 20% of the original amount. $5,000 of this benefit is paid up in an Allstate Annuity.
Duncan Union & Non-Union Jan. 1, 1985 through Sale of Assets	**If you were a union employee:** • If you had participated in contributory life insurance for at least 10 years as of the day before the date of retirement, you were provided with retiree life insurance equal to the lesser of one times annual base pay or $50,000. • If you were **not** participating in the contributory coverage as described above, you were provided with $2,000 in flat-term life insurance. • In either situation above, your coverage was/will be reduced by 50% on the day you reached age 70. **Non-Union:** You were provided with retiree life insurance coverage equal to the lesser of one times annual salary or $50,000. Each year, your coverage was reduced by 20% of the original amount until it reached $5,000.
El Dorado Union Prior to All Dates to Sale of Assets	The Plan provides employees term life insurance of an amount equal to two-and-one-half times your basic annual earnings (for a normal workweek not exceeding 40 hours, exclusive of bonus and overtime pay), adjusted to the next-higher multiple of $500, if not already a multiple. The maximum term life insurance is $200,000. Upon retirement from the Company, you were provided with retiree life insurance coverage based upon your length of service with the Company before your retirement, as follows: **Length of service** — **Maximum amount** Less than 10 years — $2,250 10 but less than 20 years — $5,063 20 years or more — $6,188
El Dorado Non-Union Prior to Jan. 1, 1985	The Plan provides employees term life insurance of an amount equal to two-and-one-half times your basic annual earnings (for a normal workweek not exceeding 40 hours, exclusive of bonus and overtime pay), adjusted to the next-higher multiple of $500, if not already a multiple. The maximum term life insurance is $200,000. Upon retirement from the Company, you were provided with retiree life insurance coverage based upon your length of service with the Company before your retirement, as follows: **Length of service** — **Minimum amount** — **Limited percentage** 10 but less than 20 years — $3,375 — 15% 20 years or more — $4,125 — 25%
El Dorado Non-Union Jan. 1, 1985 through Sale of Assets	You were provided with retiree life insurance coverage equal to the lesser of one times annual salary or $50,000. Each year, your coverage was reduced by 20% of the original amount until it reached $5,000.
Chemical Prior to Aug. 31, 2000	You were provided with retiree life insurance equal to the amount indicated on the Company's retirement records.
Tosco Prior to Jan. 1, 1988	You were provided with retiree life insurance coverage equal to the lesser of one times annual salary or $50,000. Each year on your retirement anniversary date, your coverage was reduced by 20% of the original amount until it reached $5,000.
All Other Assets or Dates	Retiree life insurance was not available.

COG Operating LLC Employees

If you were an employee of COG Operating LLC on Jan. 15, 2021 when COG was acquired by ConocoPhillips, you became a ConocoPhillips employee on Jan. 1, 2022; however, you were not eligible for retiree life insurance. On Jan. 1, 2023, your years of service at COG Operating LLC were added to the ConocoPhillips years of service to determine the points accrued under the 65-point rule for retiree life insurance eligibility. **Note:** COG Operating LLC also known as Concho Resources.

Shell Enterprises LLC Employees

If you were a former Shell Enterprises LLC employee who transferred to ConocoPhillips with the Permian assets and had been hired by Shell on or after Jan. 1, 2018, the years of service at Shell will be added to the ConocoPhillips years of service on Dec. 1, 2023 to determine the points accrued under the 65-point rule. If instead, you were the transferred employee who was hired by Shell prior to Jan. 1, 2018, your years of service at Shell were added to the ConocoPhillips years of service upon transfer to ConocoPhillips to determine the points accrued under the 65-point rule for retiree life insurance eligibility.

ConocoPhillips