

ConocoPhillips Medical Plan: High Deductible Health Plan (HDHP)

Coverage Period: 01/01/2013–12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual and Family | **Plan Type:** HDHP



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at hr.conocophillips.com or by calling 1-800-622-5501.

Important Questions	Answers	Why this Matters:		
What is the overall <u>deductible</u> ?	For each calendar year: \$1,400 Individual \$2,800 Family In-network and out-of-network combined. Includes medical and prescription drug costs. Does not apply to preventive care in-network.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .		
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.		
Is there an <u>out-of-pocket limit</u> on my expenses?	<table border="0"> <tr> <td>Yes. In-Network: \$4,000 Individual \$8,000 Family</td> <td>Yes. Non-Network: \$5,000 Individual \$10,000 Family</td> </tr> </table> Includes medical and prescription drug costs.	Yes. In-Network: \$4,000 Individual \$8,000 Family	Yes. Non-Network: \$5,000 Individual \$10,000 Family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
Yes. In-Network: \$4,000 Individual \$8,000 Family	Yes. Non-Network: \$5,000 Individual \$10,000 Family			
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, penalties for failure to obtain preauthorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .		
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.		
Does this plan use a <u>network of providers</u> ?	Yes. For a list of in-network providers, see www.aetna.com or call 1-800-738-7674.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .		
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission from this plan.		
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .		

Questions: Call 1-800-622-5501 or visit us at <http://resources.hewitt.com/conocophillips>.

IMS Number H000109377

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-866-444-3272 to request a copy.

- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Network Provider	Non-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Other practitioner office visit	20% coinsurance	40% coinsurance	Coverage is limited to 20 visits per calendar year for chiropractor.
	Preventive care/screening/immunization	No charge	No charge up to \$1,500, then 40% coinsurance, deductible waived	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Some services require pre-certification. See Preventive Care for services billed as preventive.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Some services require pre-certification.

Common Medical Event	Services You May Need	Your Cost if You Use a		Limitations & Exceptions
		Network Provider	Non-Network Provider	
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.medco.com or by calling 1-800-770-2810.</p>	Generic Drugs	<p>Retail and Mail Order: You pay 100% until deductible is met, then 20% coinsurance.</p> <p>Preventive drugs covered at 100% up to \$1,500 per person per year, then 20% coinsurance.</p>	<p>Retail: You pay the full price then file a claim. You pay 100% until the annual deductible is met, then 40% coinsurance plus amounts above the negotiated/discounted rate.</p> <p>Mail Order: N/A</p>	<p>Retail covers up to a 30-day supply.</p> <p>Mail order covers up to a 90-day supply.</p> <p>You pay 100% of the difference in cost if you obtain a brand name drug when a generic brand is available.</p> <p>You pay 100% of the cost for maintenance medications if obtained from a retail pharmacy after the second refill.</p>
	Preferred Brand Drugs	<p>Retail and Mail Order: You pay 100% until deductible is met, then 20% coinsurance.</p> <p>Preventive drugs covered at 100% up to \$1,500 per person per year, then 20% coinsurance.</p>	<p>Retail: You pay the full price then file a claim. You pay 100% until the deductible is met, then 40% coinsurance plus amounts above the negotiated/discounted rate.</p> <p>Mail Order: N/A</p>	<p>You pay 100% of the cost for maintenance medications if obtained from a retail pharmacy after the second refill.</p>
	Non-Preferred Brand Drugs	<p>Retail and Mail Order: You pay 100% until deductible is met, then 20% coinsurance.</p> <p>Preventive drugs covered at 100% up to \$1,500 per person per year, then 20% coinsurance.</p>	<p>Retail: You pay the full price then file a claim. You pay 100% until the deductible is met, then 40% coinsurance plus amounts above the negotiated/discounted rate.</p> <p>Mail Order: N/A</p>	<p>You pay 100% of the cost for maintenance medications if obtained from a retail pharmacy after the second refill.</p>
	Specialty Drugs	<p>Retail and Mail Order: You pay 100% until deductible is met, then 20% coinsurance.</p> <p>Preventive drugs covered at 100% up to \$1,500 per person per year, then 20% coinsurance.</p>	<p>Retail: You pay the full price then file a claim. You pay 100% until the deductible is met, then 40% coinsurance plus amounts above the negotiated/discounted rate.</p> <p>Mail Order: N/A</p>	<p>May be subject to prior authorization, preferred drug step therapy if generic brand is available and quantity/dose limits.</p> <p>Prescriptions for certain self-injectable and oral medications must be submitted to prescription drug claims administrator.</p>

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Network Provider	Non-Network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	————None————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	————None————
If you need immediate medical attention	Emergency room services	20% coinsurance for emergency 50% coinsurance for non-emergency	20% coinsurance for emergency 50% coinsurance for non-emergency	————None————
	Emergency medical transportation	20% coinsurance for emergency 40% coinsurance for non-emergency	20% coinsurance for emergency 40% coinsurance for non-emergency	————None————
	Urgent care	20% coinsurance	40% coinsurance	No deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-certification may be required. Benefits will be reduced by \$200 if pre-certification is not obtained.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	————None————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance	Authorization may be required for non-emergency situations.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	————None————
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	————None————

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Network Provider	Non-Network Provider	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Coverage is limited to 120 visits per calendar year. Pre-certification required for non-network care. Benefits will be reduced by \$200 if pre-certification is not obtained.
	Rehabilitation services	20% coinsurance	40% coinsurance	————None————
	Habilitation services	Not covered	Not covered	————None————
	Skilled nursing care	20% coinsurance	40% coinsurance	Coverage is limited to 60 days per calendar year. Pre-certification required for non-network care. Benefits will be reduced by \$200 if pre-certification is not obtained.
	Durable medical equipment	20% coinsurance	40% coinsurance	————None————
	Hospice service	20% coinsurance	40% coinsurance	Pre-certification required for non-network care. Benefits will be reduced by \$200 if pre-certification is not obtained.
If your child needs dental or eye care	Eye exam	Preventive: No charge. Non-preventive: 20% coinsurance.	Preventive: No charge up to \$1,500, then 40% coinsurance, deductible waived thereafter. Non-preventive: 40% coinsurance.	————None————
	Glasses	Not covered	Not covered	————None————
	Dental check-up	Not covered	Not covered	————None————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Glasses 	<ul style="list-style-type: none"> • Habilitation services • Hearing aids • Long-term care 	<ul style="list-style-type: none"> • Routine foot care • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if medically necessary or in lieu of anesthesia)
- Bariatric surgery (pre-certification required)
- Chiropractic care
- Infertility treatment (includes artificial insemination and in-vitro fertilization up to \$10,000 lifetime maximum)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (70 eight-hour shifts)
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-800-622-5501**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact hr.conocophillips.com or call **1-800-622-5501**. You can also contact the Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform.

Language Access Services:

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

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

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

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

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$4,920
- Patient pays \$2,620

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$1,400
Copays	\$0
Coinsurance	\$1,220
Limits or exclusions	\$0
Total	\$2,620

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,220
- Patient pays \$2,180

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,400
Copays	\$0
Coinsurance	\$780
Limits or exclusions	\$0
Total	\$2,180

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-622-5501 or visit us at <http://resources.hewitt.com/conocophillips>.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-866-444-3272 to request a copy.