Employee Dental Plan

C

Introduction

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

You may be eligible for the following dental options:

- The CP Dental option, a passive Preferred Provider Organization (PPO); and
- The Preventive Dental option, a passive Preferred Provider Organization (PPO) for preventive dental services only. **Note:** This option isn't available to store employees and under-age-65 heritage Tosco former employees receiving long-term disability benefits with eligibility designated on Company records.

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

"Glossary," page M-1

In this chapter, the term "Company" is used to describe ConocoPhillips and the other companies whose employees are covered by this Plan (as shown in "Employers Participating in the Plan" on this page).

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

EMPLOYERS PARTICIPATING IN THE PLAN

As of Jan. 1, 2012, the most significant employers participating in the Plan are listed below. A complete current list of employers participating in the Plan may be obtained at any time, free of charge, from the Plan Administrator.

- ConocoPhillips Company
- ConocoPhillips Pipe Line Company
- Phillips Utility Gas Corporation

"Plan Administration," page I-5

STORE EMPLOYEES AND CERTAIN HERITAGE TOSCO FORMER EMPLOYEES

Store employees and under-age-65 heritage Tosco former employees receiving long-term disability benefits with eligibility designated on Company records who are eligible for the coverage outlined in this chapter aren't eligible for the Preventive Dental option. Any references to the Preventive Dental option don't apply to these two groups.

Who Is Eligible

RIVERHEAD PIPELINE UNION MEMBERS AND EMPLOYEES ELIGIBLE FOR AETNA GLOBAL BENEFITS

Members of the Riverhead Pipeline Union, inpatriate employees and U.S. expatriate employees **are not** eligible for the Employee Dental Plan.

EMPLOYEE ELIGIBILITY

If you're an active, regular full-time or regular part-time[1] employee, you're eligible to participate in the Plan if you're:

- A U.S. citizen or resident alien employee working within the U.S. (includes rotators) who is paid on the direct U.S. dollar payroll[2]; or
- A U.S. citizen or resident alien employee working within the U.S. (includes rotators) who is paid on the direct U.S. dollar payroll[2] and who is on a personal, disability or military leave of absence or on a family medical leave of absence or is an under-age-65 heritage Tosco former employee receiving long-term disability benefits with eligibility designated on Company records.

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

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

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

[1] *Regular part-time employees must work on average at least 20 hours per week.*

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

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

"Contacts," page A-1

If Your Eligible Dependent Is Also a Company Employee or Retiree

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

"Dependent Eligibility," page C-4

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

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

"Changing Your Coverage," page C-7

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

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

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

DEPENDENT ELIGIBILITY

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

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

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

- Spouse[2] (including your state-recognized common-law spouse[3]; excluding a spouse after a divorce or separation by a legal separation agreement[4]) 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; or
  - Your stepchild, provided the biological 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/domestic partner's child if he or she is:
  - Under age 26; 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 the earlier of his or her reaching age 26 or initial eligibility after age 26.

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

- Is on active duty in any military service of any country (excluding weekend duty or summer encampments);
- Is not a U.S. citizen, resident alien or resident of Canada or Mexico;
- Is already covered under a Company dental plan as an employee, retiree or as a dependent of either (including COBRA participants and excluding the Retiree Dental-UHC option);
- 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 under a legal guardianship agreement; or
- Is in a relationship with you that violates local law.

[1] *If you enroll in the Aetna Global Benefits option, refer to the Certificate of Coverage for any additional eligibility provisions.*

[2] *The marriage must meet the definition of the federal Defense of Marriage Act of 1996.*

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

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

If You Enroll an Ineligible Dependent

If you enroll a dependent who doesn't meet the Plan's dependent eligibility requirements or don't cancel coverage within 30 calendar days of when a dependent ceases to meet the Plan's dependent eligibility requirements, he or she will be considered an ineligible dependent. The Plan has the right to request reimbursement of any claims or expenses paid for an ineligible dependent. If canceling your ineligible dependent's coverage reduces your cost for coverage, any amounts you have overpaid will not be refunded. In addition, you may be subject to disciplinary action — up to and including termination of coverage for benefits in the applicable Plan or termination of employment by the employer for enrolling or keeping an ineligible dependent in the Plan. If coverage is rescinded, the Plan will give the participant a 30-calendar-day advance written notice prior to rescission.

Certification of Eligible Dependents

When you enroll your eligible dependent(s) in your dental coverage — and when you continue their participation at each annual enrollment — you're certifying that the person is an eligible dependent under the terms of 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 Plan Administrator. Failure to provide the certification and/or the requested documents verifying proof of dependent eligibility will delay the dependent's coverage under the Plan. See *hr.conocophillips.com* or contact the Benefits Center for details or if you have any questions about this requirement.

"Contacts," page A-1

How to Enroll, Change or Cancel Coverage

If you want to enroll in dental coverage for yourself or your eligible dependents, you enroll online or call the Benefits Center. If you have questions about the enrollment procedure, contact the Benefits Center.

"Contacts," page A-1

When you enroll, you'll:

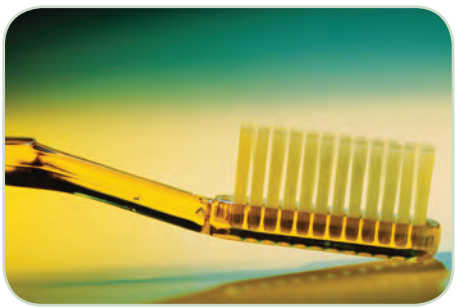
- Choose from the Plan options available to you;
- Decide which of your eligible dependents you wish to cover, if any; and
- Authorize any required payroll deductions for the cost of the coverage you select.

Your enrollment materials will contain information to help you make your enrollment elections. Contact the Benefits Center if you need more information.

"Contacts," page A-1

✔ 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, you can choose to enroll different dependents in your dental coverage than in your medical coverage.

Note: The dental Claims Administrator does **not** issue ID cards.



WHEN TO ENROLL, CHANGE OR CANCEL COVERAGE

You can enroll, change or cancel Plan coverage:

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

"Changing Your Coverage," page C-7

✔ If you fail to enroll your eligible newborn child in your dental option within 30 days after the birth date, dental coverage will be provided only for his or her first 31 calendar days after birth. You will **not** be able to enroll the newborn until the next annual enrollment, with coverage to begin the following Jan. 1.

WHEN COVERAGE BEGINS

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

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

[1] *If an enrollment action is not made within 30 calendar days after the event, you won't be able to make the enrollment action until the next annual enrollment period (absent another enrollment event), with coverage effective the first of the following calendar year.*

✔ If you're a surviving spouse/domestic partner or eligible child, see "In the Event of Your Death."

"In the Event of Your Death," page C-21

CHANGING YOUR COVERAGE

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

If you don't report the change to the Benefits Center within 30 calendar days 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.**

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

"Contacts," page A-1

"Change in status" changes may include:

- Your marriage, divorce, legal separation or annulment;
- Death of an eligible dependent;
- Addition of an eligible dependent through birth, adoption or placement for adoption. (Even if you already have *You + Two or More* coverage, you need to enroll your new eligible dependent(s) in order for their coverage to take effect. If you fail to enroll your eligible newborn child in your dental option within 30 days after the birth date, dental coverage will be provided only for his or her first 31 calendar days after birth);
- A Qualified Medical Child Support Order that requires you to provide dental coverage for a child;
- A change in employment status by you or your eligible dependent;
- A change in work schedule by you or your eligible dependent that changes coverage eligibility;
- A change in your eligible dependent's status;
- You and/or your eligible dependents become entitled to COBRA;
- The taking of or return from a leave of absence under the Family Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act of 1994; and
- You or your eligible dependents have a significant change in benefits or costs, such as benefits from another employer, etc.

✔ If a change by you or your eligible dependent terminates eligibility for your dental option or if your dental option is eliminated, your coverage will automatically be changed to the Preventive Dental option unless you enroll otherwise.

The Plan Administrator 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 YOU TAKE A LEAVE OF ABSENCE

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

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

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

"Who Is Eligible," page C-3; "How to Enroll, Change or Cancel Coverage," page C-5

If You're on a Military Leave of Absence

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

"USERRA Continuation Coverage," page L-26

IF YOU HAVE A LEAVE OF ABSENCE-LABOR DISPUTE

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

What the Plan Costs

You and the Company share in the cost of dental coverage. The Company pays approximately 80% of the CP Dental option rate and 100%[1] of the Preventive Dental option rate. **Note:** The Company contribution for the CP Dental option is approximately 50% for store employees. Your cost for coverage for yourself and your dependents is based on the Plan option and level of coverage you elect *(You Only, You + One, You + Two or More)*, regardless of your scheduled workweek hours (regular full-time or regular part-time). Cost sharing is designated with Plan eligibility on Company records for under-age-65 heritage Tosco former employees receiving long-term disability benefits.

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

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

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

The Plan Administrator has authority to make temporary changes applicable for 30 days or less in Plan provisions as appropriate, at the Plan Administrator's discretion, to respond to a natural or manmade emergency or disaster so participants can obtain covered services. In any such instance, the Plan Administrator shall adopt administrative procedures specifying the changes and the duration of such changes.

[1] *Subject to change to comply with requirements of health care reform legislation and current and future government guidance.*

Employee Dental Benefit Highlights

✔ If you're enrolled in Aetna Global Benefits, please refer to the materials provided by Aetna for information about your coverage.

✔ The list of Plan benefits at right 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 C-13

STORE EMPLOYEES AND CERTAIN HERITAGE TOSCO FORMER EMPLOYEES

Store employees and under-age-65 heritage Tosco former employees receiving long-term disability benefits with eligibility designated on Company records aren't eligible for the Preventive Dental option of the Plan. Any references to the Preventive Dental option don't apply to these groups.

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

"Covered Expenses," page C-14; "Non-Covered Expenses," page C-16

	Preventive Dental Option	CP Dental Option
General Information		
Annual deductible	None	$50 individual; $150 family maximum
Annual maximum benefit	$2,000 per person	$2,000 per person
Diagnostic and Preventive Services[2]	**What You Pay[1]**	**What You Pay[1]**
Oral Exams	$0, no deductible	$0, no deductible
Bitewing/Full Mouth X-Rays	$0, no deductible	$0, no deductible
Cleaning and Scaling	$0, no deductible	$0, no deductible
Prophylaxis Treatments	$0, no deductible	$0, no deductible
Fluoride Treatments	$0, no deductible	$0, no deductible
Space Maintainers *(for missing primary teeth)*	$0, no deductible	$0, no deductible
Sealants	$0, no deductible	$0, no deductible
Basic Services[2]	**What You Pay[1]**	**What You Pay[1]**
Fillings *(amalgam, composite, synthetic porcelain and plastic restorations)*	Not covered	20% after deductible
Endodontic treatment	Not covered	20% after deductible
Periodontic treatment	Not covered	20% after deductible
Re-linings and re-basings of existing removable dentures	Not covered	20% after deductible
Repair or re-cementing of existing crowns, inlays, onlays, dentures or bridgework	Not covered	20% after deductible
Oral surgery *(extractions and related surgical procedures)*	Not covered	20% after deductible

See footnotes on page C-11.

(continued)

	Preventive Dental Option	CP Dental Option
Major Services[2]	What You Pay[1]	What You Pay[1]
Crowns, inlays, onlays, jackets and cast restoration benefits	Not covered	50% after deductible
Implant services *(repair, maintenance and removal)*	Not covered	50% after deductible
Oral surgery *(root, periodontal and implant surgeries)*	Not covered	50% after deductible
Orthodontia Services[2]	What You Pay[1]	What You Pay[1]
Orthodontia	Not covered	50%
You and your eligible dependents	Not covered	Covered
Lifetime maximum orthodontia benefit[3]	Not covered	$2,000/per person

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

"Glossary," page M-21

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

"Covered Expenses," page C-14

[3] *This maximum is separate from the Plan's annual maximum benefit. The increased orthodontia lifetime maximum of $2,000 will apply to any new orthodontia charges incurred on and after Jan. 1, 2011 as well as patients who were in active orthodontic treatment that extended into 2011.*

How Employee Dental Works

✔ The Preventive Dental option isn't available to store employees or to under-age-65 heritage Tosco former employees receiving long-term disability benefits with eligibility designated on Company records.

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

> Any participating network provider (if available) who has agreed to charge participants a contracted MetLife Preferred Dentist Program (PDP) fee, which is usually lower than those charged by non-network providers and is not subject to reasonable and customary provisions, and to file the dental claims for you; or

> A non-network provider. Services received from non-network providers **are** subject to reasonable and customary provisions.

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

"Employee Dental Benefit Highlights," page C-10; "Covered Expenses," page C-14

TO FIND A NETWORK PROVIDER

> Ask your provider if he or she is in the MetLife Preferred Dentist Program (PDP) network.

> Access the Claims Administrator's website for network information, or call the Claims Administrator and get the information over the phone.

"Contacts," page A-1

It's your responsibility to ensure that you use MetLife network providers if you want to receive the benefit of lower, contracted rates. Keep in mind that network providers occasionally change and that some areas do not have network providers, so you'll want to make sure the dentist you choose is still in the MetLife network before you make an appointment. For the most up-to-date information, including whether a dentist is accepting new patients, call the provider directly.

SOME BASIC TERMS

Annual Deductible

✔ In order to encourage preventive care, the CP Dental Option's annual deductible is waived for covered preventive services, up to Plan limits. It's also waived for orthodontic services, up to Plan limits.

"Employee Dental Benefit Highlights," page C-10

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

> **If you have *You Only* coverage:** You must meet the annual individual deductible before most benefit payments begin.

> **If you have *You + One* coverage:** Each covered individual must meet the annual individual deductible before most benefit payments for that individual begin.

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

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

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

> Diagnostic and preventive services;

> Expenses not covered by the CP Dental option;

> Expenses in excess of reasonable and customary limits; or

> Orthodontic services.

Coinsurance

"Coinsurance" is the percentage of covered expenses you pay for dental services once you satisfy any required annual deductibles. For example, once you've met the annual deductible, your coinsurance percentage is 20% of the reasonable and customary amount of covered expenses for basic services and 50% of the reasonable and customary amount for major services. You are responsible for any expenses in excess of reasonable and customary limits.

"Employee Dental Benefit Highlights," page C-10

Annual Maximum Benefit

The annual maximum benefit is the maximum amount the Plan will pay each calendar year for each covered person's covered dental services. This amount is separate from the lifetime maximum benefit for orthodontia described below.

Lifetime Maximum Benefit for Orthodontia

A lifetime maximum benefit applies in the CP Dental option for each covered person's covered orthodontia treatment. The lifetime maximum — which is separate from the annual maximum benefit described above — is calculated beginning with orthodontia benefits paid in 2007. Benefits paid prior to 2007 don't apply.

Alternate Benefit

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

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

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

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

When the benefit paid is based on the less costly service, the dentist may charge you or your dependent for the difference between the service that was performed and the less costly service, even if the service is performed by a network provider.

IMPORTANT PLAN FEATURES

Predetermination of Benefits

Predetermination of benefits is your opportunity to review if a service is medically necessary and if costs of certain dental treatments recommended by your dentist are reasonable and customary. You decide whether you want to obtain a predetermination of benefits — there is no reduction in benefits if a predetermination isn't obtained. However, obtaining a predetermination can help ensure the appropriateness of the proposed treatment and may be able to reveal other options. It can help you determine what the Plan will pay and what will be your responsibility to pay.

Call the Claims Administrator and request a predetermination of benefits form if you want to:

"Contacts," page A-1

- See if a proposed treatment is covered by the Plan;
- Receive an estimate of what you'll pay for the proposed treatment; and
- See whether the fee for the treatment is within the Plan's reasonable and customary guidelines.

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

If You're Outside the United States

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

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

"Contacts," page A-1

COVERED EXPENSES

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

"Employee Dental Benefit Highlights," page C-10; "Annual Deductible," page C-12; "Non-Covered Expenses," page C-16

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

Preventive and Diagnostic Services

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

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

[1] *The Plan will cover the cost of the X-ray or the cost of full-mouth X-rays, whichever is less.*

Basic Restoration Services

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

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

Major Restoration Services

Major restoration services include the following restoration and prosthodontic procedures:

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

Orthodontia Treatment

Orthodontia treatment for children and adults includes:

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

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

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

"Lifetime Maximum Benefit for Orthodontia," page C-13

NON-COVERED EXPENSES

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

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

"Dental-Related Expenses," page B-21

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

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

How to File a Claim

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

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

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

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

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

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

"Contacts," page A-1

✔ **Dental claims must be received no later than Dec. 31 of the year following the date service was rendered.** For example, a claim dated March 2012 must be received no later than Dec. 31, 2013. Claims received after the Dec. 31 deadline are not eligible for payment under the Plan.

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

"Medical, Dental, FSP and Employee Assistance Plan Claims," page L-41

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 L-35

Coordination of Benefits (COB)

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

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

✔ The Employee Dental Plan uses standard coordination of benefits. Standard Coordination of Benefits approach pays the difference between what the primary carrier paid and the allowable fee. Standard Coordination of Benefits is a cooperative claim payment between two or more insurance carriers that applies when a member is covered under more than one plan. Reimbursement between the carriers can result in a 100% reimbursement of benefit. However, the member will not realize a profit above the 100% reimbursement. You're required to tell the Claims Administrator if you or your dependents have other coverage.

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

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

  "COBRA Continuation Coverage," page L-15
- The plan covering an individual as an employee (or as an employee's dependent) who is neither laid-off or retired is primary. The plan covering the individual as a laid-off or retired employee (or that individual's dependent) is secondary.
- If none of the above rules apply, the plan that has covered the individual longer is primary, and the plan that has covered the individual for less time is secondary.

When Coverage Ends

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

- Through COBRA continuation coverage;

  "COBRA Continuation Coverage," page L-15
- Through retiree coverage.

  *Refer to the separate **Retiree Benefits Handbook** available from the Benefits Center or on **hr.conocophillips.com***

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

"In the Event of Your Death," page C-21

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

- The last day of the month in which your employment ends for any other reason not stated in this section (excludes heritage Tosco former employees receiving long-term disability benefits with Plan eligibility designated on Company records whose coverage ends the earliest of either a) the last day of the month prior to Medicare eligibility due to reaching age 65; or b) the last day of the month in which long-term disability benefits terminate);
- The last day of the month in which you no longer meet the Plan's eligibility requirements;

  "Employee Eligibility," page C-3
- The last day of the month in which your coverage is terminated for any reason;
- The last day of the month in which you don't pay the required cost for coverage;
- The date of your death (see "In the Event of Your Death" for information about continued dental coverage for your surviving dependents);

  "In the Event of Your Death," page C-21

- The last day of the month in which your leave of absence-Labor Dispute begins;
- If you have continued coverage during a leave of absence and you don't return to work as an employee at the end of the leave, on the last day of the month in which the earliest of the following events occurs:
  - The leave expires; or
  - You first notify the Company that you don't intend to return to work; or
- The date on which the ConocoPhillips Employee Dental Plan is terminated.

Note: If coverage is terminated or lowered during the month, no reimbursements for any difference in dental coverage level *(You, You + One, You + Two or More)* are made for the month.

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

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

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

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

IN THE EVENT OF YOUR DEATH

Survivor coverage does **not** apply to store employees or to the children of a domestic partner.

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

"COBRA Continuation Coverage," page L-15

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

"COBRA Continuation Coverage," page L-15

If your surviving spouse and eligible children weren't covered under a dental option on the date of your death, they'll be notified if they are eligible for any of the Retiree Medical Plan dental coverage options and given the opportunity to enroll.

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

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

"Who Is Eligible," page 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 under the Plan is continuous.