Employee Executive Life Insurance

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This is the Summary Plan Description (SPD) for the ConocoPhillips Group Universal Life Insurance Plan. The insurance certificate/policy of coverage that you receive when you enroll and any Summaries of Material Modifications that are issued are considered a part of the SPD. Some employees are not eligible to participate in the Plan described in this SPD. Receipt of this SPD does not mean you are eligible to participate in this Plan. To be eligible to participate in this Plan, you must meet the eligibility requirements outlined in the SPD. Every effort has been made to ensure the accuracy of this SPD. If there is any conflict between this SPD and the official Plan documents (including an insurance contract), the official Plan documents will control. Nothing in this SPD creates an employment contract between ConocoPhillips Company or its subsidiaries and affiliates and any employee. 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 Your Employee Executive Life Insurance Handbook!

This handbook provides you with important information about a group life insurance benefit available to employees in your job classification. Please take the time to review your handbook. It is an easy-to-use resource that gives you the information you need to maximize your Plan benefits.

FEATURES TO HELP YOU

Within the handbook, you'll find features to help increase your understanding of the Plan. These features include:

- **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.
- **Glossary** — Some benefit terms used in this handbook have very specific meanings. These terms are underlined throughout the text, 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 be sent a notice of what's changing and when. Be sure to file any updates in the pocket of this handbook for easy access.

Contacts

The Plan has a Plan Administrator who 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 Plan, including the filing of claims.

- Contact information for MetLife, the Claims Administrator, is shown in the box below.
- See "How to File a Claim" for details on filing a benefit claim.
  "How to File a Claim," page 10
- See "Claims and Appeals Procedures" for information on how to appeal a denied claim and for the Appeals Administrator's contact information.
  "Claims and Appeals Procedures," page 14
- See "Plan Administration" for description of the Plan Administrator's rights and responsibilities and his contact information.
  "Plan Administration," page 12

CONTACT INFORMATION

For Information On:	Contact/Address	Phone/Operating Hours
Group Universal Life/Group Variable Universal Life - To view coverage	Benefits Center 7201 Hewitt Associates Center P.O. Box 563994 Charlotte, NC 28256-3994 - Visit *hr.conocophillips.com* to see benefit plan information - Visit Your Benefits Resources (YBR) through HR Express (for active employees only), or at *http://resources.hewitt.com/conocophillips* for personal and benefit plan information	(800) 622-5501 or (718) 354-1344 8:00 a.m. to 6:00 p.m. Central time, Monday – Friday, except U.S. Company holidays
- To enroll - For questions about coverage or rates - Coverage or beneficiary changes - To report a claim	MetLife GUL/GVUL Claims and Appeals Administrator 13045 Tesson Ferry St. Louis, MO 63128 **Web:** *gvuleservice.metlife.com or hr.conocophillips.com*	*MetLife* (800) 756-0124 *(if enrolled)* 7:00 a.m. to 7:00 p.m. Central time, Monday – Friday (800) 846-0124 *(if not enrolled)* 8:00 a.m. to 5:00 p.m. Central time, Monday – Friday

Introduction

The ConocoPhillips Employee Executive Life Insurance Plan (the Plan) provides Group Variable Universal Life (GVUL) or Group Universal Life (GUL) insurance coverage, which provides your family with valuable financial protection in the event of your death. The Plan includes an optional cash accumulation feature, which may generate earnings for you on a tax-deferred basis.

Note: You should refer to the prospectus you receive before purchasing this insurance. This Summary Plan Description (SPD) is an overview of the Plan and does not contain the detail that the prospectus will provide.

Please refer to the Glossary beginning on page 19 for the definitions of underlined terms used throughout this SPD.

"Glossary," page 19

In this chapter, the term "Company" refers to ConocoPhillips and the other companies that have adopted this Plan (as shown in "Employers Participating in the Plan" on this page).

For information on retiree life insurance 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, 2010, 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
- ConocoPhillips Expatriate Services Company
- International Energy Limited

"Plan Administration," page 12

Who Is Eligible

If you're an active, regular full-time or regular part-time[1] employee, grade 19 through 35, age 17 and above and not enrolled in the supplemental option of the Group Life Insurance Plan, you're eligible to participate in the Plan if you're:

- A non-store U.S. citizen or resident alien employee working **within** the U.S. (includes rotators) and paid on the direct U.S. dollar payroll[2];
- A non-store U.S. citizen or resident alien employee working **within** the U.S., paid on the direct U.S. dollar payroll[2] and on a **personal or disability leave of absence or family medical leave of absence (FMLA)**;
- A non-store U.S. citizen or resident alien employee working **within** the U.S., paid on the direct U.S. dollar payroll[2] and on a **military leave of absence**;
- A non-store U.S. citizen or resident alien employee working **outside** the U.S. and paid on the direct U.S. dollar payroll[2] (known as a **U.S. expat**);
- A non-store U.S. citizen or resident alien employee working **outside** the U.S. and paid on the direct U.S. dollar payroll[2] (known as a **U.S. expat**) and on a **personal or disability leave of absence or family medical leave of absence (FMLA)**;
- A non-store U.S. citizen or resident alien employee working **outside** the U.S. and paid on the direct U.S. dollar payroll[2] (known as a **U.S. expat**) and on a **military leave of absence**;
- An employee employed by International Energy Limited (known as an **IEL**).

[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.*

✔ The insurance company must approve eligible employees who work for the Company in a country outside the United States or are over the age of 70.

You're **not** eligible to participate in the Plan if:

- You're not an active, regular full-time or regular part-time employee; or
- You're a member of a recognized or certified collective bargaining unit; or
- Your employee classification isn't described in this section.

For example, temporary employees, independent contractors and commission agents aren't eligible to participate in the Plan.

✔ **Note:** If you are participating in the Plan and then have your salary grade reduced below grade 19, you will not lose your eligibility. You will remain in the Plan with all options available the same as any other eligible employee participating in the Plan and you will continue paying by the payroll deduction method. If you are not participating in the Plan at the time of the salary grade reduction, you may not then enroll.

How to Enroll, Change or Cancel Coverage

If you want to enroll in, change or cancel group universal life insurance coverage, go to *hr.conocophillips.com* or *gvuleservice.metlife.com*. If you have questions about the enrollment procedure, contact the Claims Administrator.

"Contact Information," page 3

When you enroll, you'll:

- Choose from the Plan options available to you; and
- Authorize any required payroll deductions for the coverage you select.

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

"Contact Information," page 3

WHEN TO ENROLL, CHANGE OR CANCEL COVERAGE

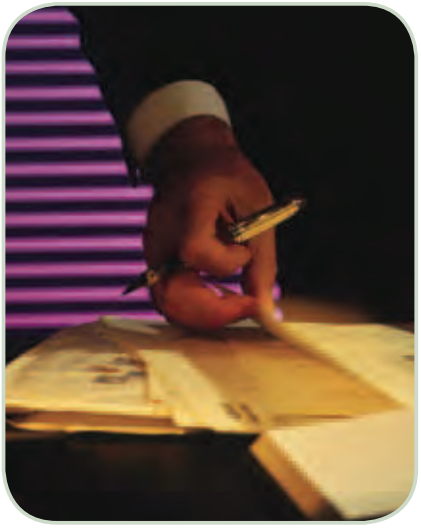
You can enroll, change or cancel coverage at any time. But evidence of insurability (EOI) may be required for certain coverage elections. You cannot be in the hospital on the day you apply for coverage.

After your coverage is effective, the insurance company will send you a policy certificate explaining your coverage and your rights under the policy. The policy certificate will be mailed to your address of record with ConocoPhillips. You have a 20-day period to review your certificate and decline coverage if you decide you do not want coverage.

✔ At the time of enrollment in this Plan, eligible employees who are working or residing outside of the United States only can enroll for GUL coverage (limited to a general interest-bearing account). If you return to the United States for any reason (personal or business) other than to enroll in this Plan, you may exchange your GUL certificate for a GVUL certificate.

✔ Group universal life insurance is not available if you have coverage under the supplemental option of the ConocoPhillips Group Life Insurance Plan.

✔ If you wish to enroll in GVUL upon your initial eligibility, you will be issued the same amount of coverage you had in the supplemental option of the Group Life Insurance Plan and no evidence of insurability will be required (known as guaranteed issue). Coverage up to the guaranteed issue amount will not be withheld pending approval of any additional coverage applied for in excess of guaranteed issue amounts.



WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability (EOI) — also known as evidence of good health — is required proof of your good health that must be approved by the Claims Administrator before you will be covered by the Plan. You must supply EOI if:

- You are a new hire electing a benefit amount of five or more times your annual pay;
- You are an active employee and did not exchange the supplemental option of the Group Life Insurance Plan for the Group Universal Life Insurance Plan within 60 days of your initial eligibility date or declined and then later requested coverage (a blood test paid for by the Claims Administrator will be required in addition to a medical questionnaire);
- You are an active employee and apply in any one year period for more than $500,000 above the amount of supplemental life insurance you had under the Group Life Insurance Plan (a blood test paid for by the Claims Administrator will be required in addition to a medical questionnaire);
- You want to increase your group universal life insurance coverage;
- You did not participate in the supplemental option of the Group Life Insurance Plan at the time you became eligible for group universal life insurance;
- Your salary increases (unless as a direct result of a promotion) more than 20% in a calendar year. Differences between actual percentage increases and 20% annually do not carry over to the subsequent calendar years; or
- You terminate your coverage and then re-enroll at a later date.

✔ Employees were allowed a one-time opportunity to increase their coverage by one salary level during annual enrollment for 2007 without providing evidence of insurability.

When Coverage Begins

Coverage will begin on the first of the month following or coincident to the later of your date of eligibility or approval of any required evidence of insurability. Coverage begins only if you're actively at work on that day. Otherwise, coverage will begin on the first date you are actively at work.

CHANGING YOUR COVERAGE

New coverage elections will take effect the first of the month following approval by the Claims Administrator and subject to any Internal Revenue Code limitations.

IF YOU TAKE A LEAVE OF ABSENCE

If you're on a leave of absence, you may continue coverage for yourself during the approved leave period — provided you make any required payments 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, your monthly costs will continue to be deducted from your paycheck on an after-tax basis.
  - If you're not receiving a paycheck from the Company, you'll be billed and will pay the cost for coverage to ConocoPhillips on an after-tax basis. (ConocoPhillips will bill you monthly during the leave for the cost for coverage.)
- If coverage continued during your leave of absence, when you return to work the Company will resume deducting the insurance costs from your paycheck on an after-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 — you must meet the same enrollment criteria as an active employee if you want to re-enroll in the Plan upon your return to work.

"Who Is Eligible", page 5; "How to Enroll, Change or Cancel Coverage," page 6

What the Plan Costs

You pay the entire cost of your coverage and any extra premium elected for your investment account with after-tax dollars deducted from your pay each month.

- The cost is based on your age (five-year bands) and coverage amount at the time of your enrollment. If a birthday moves you to a different age-band rate, the new rate is effective the next Dec. 1 coincident with or following your birthday. If your salary increases or decreases during the year, your coverage amount will change on the April 1 following or coincident with your salary increase/decrease.
- The cost may change from year to year based on your age as of Dec. 1 or annual pay as of April 1. For current costs, see your enrollment materials.

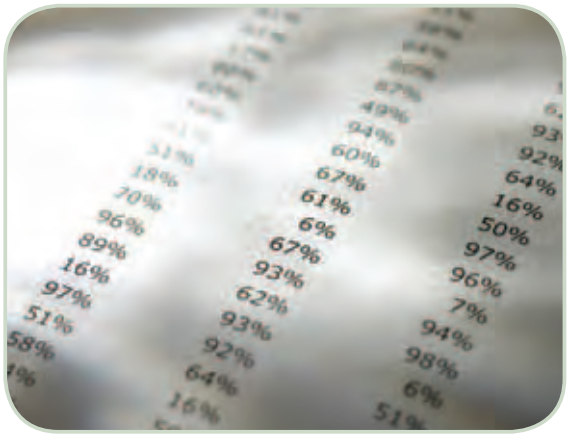
How the Plan Works

The Group Universal Life Insurance Plan includes the coverage amounts shown below.

Coverage Type	Benefit Amount
GVUL or GUL *Not available if you have coverage under the supplemental option of the ConocoPhillips Group Life Insurance Plan*	One to eight times your annual pay, rounded to the next higher $100, up to a maximum benefit of $12 million. Minimum coverage is $100,000.
Investment Account	An optional amount you elect.

The investment account is an optional benefit of the Plan. If you elect to participate in the account, you contribute an amount over and above the cost of life insurance. You may choose a GVUL plan or a GUL plan. The GVUL Plan has 14 variable account options, while the GUL Plan is limited to a general interest-bearing account. These options are explained in the enrollment materials provided to you by the insurance company. Contact the Claims Administrator for more information on the funds and their performance.

"Contact Information," page 3



The additional premium investment amount is subject to Internal Revenue Service guidelines. By using the Plan's investment feature, you can access any cash value that is built up in your certificate at any time. Unless you elect to make a change, your extra premium for investment will remain unchanged.

Once you are enrolled, the insurer will provide you quarterly (if the cash value is over $25) and annual account statements showing the amount of life insurance you have, the value of your investment account and how your investments are performing.

ACCELERATED BENEFIT OPTION

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 (see your individual policy or contact the Claims Administrator for how the amount is calculated) if you're diagnosed as terminally ill with 12 months or less to live.

To apply for accelerated benefits, contact the Claims Administrator. 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. For further details concerning this option, refer to your individual policy and contact the Claims Administrator.

How Benefits Are Paid

During your employment years, your death benefit option will be an Increasing Death Benefit. After your employment ends, you can elect to continue with the Increasing Death Benefit or change to a Level Death Benefit.

- **Increasing Death Benefit:** Your beneficiary will receive the amount of life insurance you selected plus the value of your investment account (the cash value), income tax-free.
- **Level Death Benefit:** Your beneficiary will receive the amount of life insurance you selected.

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 payment that would have gone to the convicted beneficiary will be paid to the other beneficiaries designated by you or if no other designated beneficiaries, then to your estate. Death benefits will not be paid for suicide unless the coverage has been in effect for at least two years.

Absolute Assignment

You may assign ownership of your policy without consideration by using a form provided by the Claims Administrator or online at *gvuleservice.metlife.com*. If the person the covered life has assigned the policy to (assignee) is convicted of causing your death, then neither the assignee nor the beneficiary of the assignee shall be paid any death benefits.

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 as much information as possible (e.g., full name, date of birth, Social Security number, current address).
- By law, benefits cannot be paid directly to a minor (anyone under 18 years old) — they must either be paid to the guardian of the minor's estate or held by the insurance company until the child reaches legal age. This should be taken into consideration when naming your beneficiaries.
- 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, benefits will be paid as described under "If You Don't Have a Beneficiary."

"If You Don't Have a Beneficiary," page 10

You can name or change your beneficiary designation at any time. Your beneficiary designation must be submitted on a form provided by the Claims Administrator or online on *hr.conocophillips.com* or *gvuleservice.metlife.com*. A beneficiary designation by any other means on any other document 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) sign and date it, provided the Claims Administrator has received it. A valid beneficiary designation will take effect even if you are not alive when the Claims Administrator receives it.

IF YOU DON'T HAVE A BENEFICIARY

Plan benefits will be paid to the owner of the policy if you have assigned or transferred ownership, or to your estate if you are the owner and:

- 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.

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 Universal Life Insurance Plan, your beneficiary or a family member should contact the Claims Administrator. The following information will need to be provided:

"Contact Information," page 3

- 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.

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.

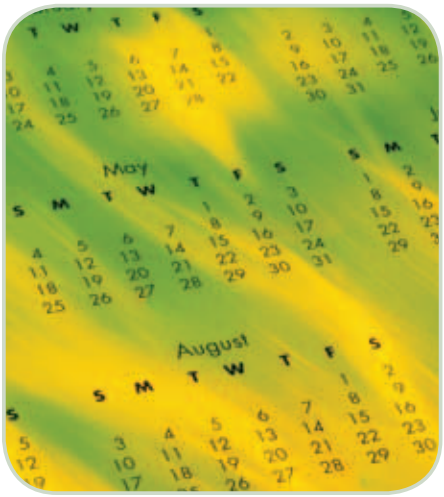
When you file a claim with the Plan, you're consenting to the release of information to the Claims Administrator and granting certain rights to the Claims Administrator.

"Information and Consents Required From You," page 15

✔ Send your completed claims and supporting documentation to the Claims Administrator shown under "Contact Information."

Questions about benefit claims should be directed to the Claims Administrator. The Claims Administrator approves or denies claims based on the applicable terms of the Plan documents, including the insurance contract.

"Contact Information," page 3



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 15

When Coverage Ends

✔ Your group universal life insurance coverage is portable, meaning you can continue coverage when you end your employment with the Company.

Your group universal life insurance coverage will end on the earliest of the following events:

- The last day of the month in which you stop paying the required costs and there is no cash value remaining to pay insurance costs. If that happens, the insurance company will notify you. You then have a 62-day grace period to pay the necessary costs before your coverage is terminated;
- The last day of the month of the coverage maturity date (policy anniversary after you reach age 95);
- The last day of the month in which your coverage is terminated for any reason; or
- The date of your death.

PORTABILITY OF INDIVIDUAL POLICY

When your employment ends, you may:

- Continue coverage and accumulate cash by paying the costs directly to the Claims Administrator on a monthly (by bank draft authorization), quarterly, semiannual or annual basis;
- Use all or part of the investment account cash balance to continue the life insurance coverage. If your cash balance becomes depleted, you must resume making your monthly payments or your coverage will be cancelled; or
- Surrender (cancel) the policy and receive your cash balance (there are no surrender charges). If you surrender the policy, you cannot reapply at a later date for an individual policy.

Other Information/ERISA

This section provides you with general information about the ConocoPhillips Group Universal Life Insurance Plan. It also gives you information you're required to receive under the Employee Retirement Income Security Act of 1974 (ERISA).

WHAT ELSE YOU SHOULD KNOW

Plan Identification Information

The Primary Employer (also is the Plan Sponsor) and Identification Number are:

ConocoPhillips Company
327-01 Adams Building
411 S. Keeler Avenue
Bartlesville, OK 74004

Employer ID#: 73-0400345

Plan Administration

The Plan has a Plan Administrator who is the named fiduciary, has discretionary authority, determines all claims and appeals for eligibility to participate in the Plan, and has the power to delegate responsibilities and authority (including discretionary authority). Some responsibilities and authority that may be delegated include reviewing claims and appeals, and construing the terms of the Plan and insurance contract.

The Plan Administrator is:

Mark Haskell (or successor)
Manager HR Shared Services (HRSS)
ConocoPhillips Company
327-01 Adams Building
411 S. Keeler Avenue
Bartlesville, OK 74004
(918) 661-6199

Agent for Service of Legal Process

For disputes arising from the Plan, legal process may be served on the General Counsel of ConocoPhillips Company (or successor). At present this is Janet Kelly. Her address is:

600 N. Dairy Ashford
Houston, TX 77079

Service of legal process may also be made upon the Plan Administrator at his or her address. For disputes arising under or connected with your insurance contract issued by the insurance company, service of legal process may be made upon the Claims Administrator.

"Contact Information," page 3

PAYMENTS TO A MINOR OR LEGALLY INCOMPETENT PERSON

For benefits under the Group Universal Life Insurance Plan the Claims Administrator may authorize payments to a conservator, guardian or other individual who is legally responsible for the management of the estate of the minor or the legally incompetent person. If the beneficiary is a minor, the Claims Administrator has the option of holding the benefits until the child reaches legal age. Interest is paid on benefits held by the insurance company.

PLAN CHANGES OR TERMINATION

The ConocoPhillips Company, acting through action of its Board of Directors or a delegate of the Board of Directors, may amend, modify, suspend or terminate a Plan, in part or in whole, at any time and from time to time. Any other employer that has adopted the Plan may end participation in the Plan for its employees and beneficiaries (in whole or in part) at any time. In the event that the Plan is terminated, or benefits are eliminated from the Plan, benefits will be paid which became payable under the terms of the Plan documents (including the insurance contract) prior to the date of the benefit elimination or Plan termination. You will be entitled to retain your individual insurance contract and your relationship will be directly with the insurer.

Your ERISA Rights

As a participant in the ConocoPhillips Group Universal Life Insurance Plan, you're entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants are entitled to:

- **Receive information about their Plan and benefits, as follows:**
  - Examine, without charge, at the Plan Administrator'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 Plan Administrator, 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 Description (the Plan Administrator 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).

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 for 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 Plan Administrator 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 Plan Administrator.

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. 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.

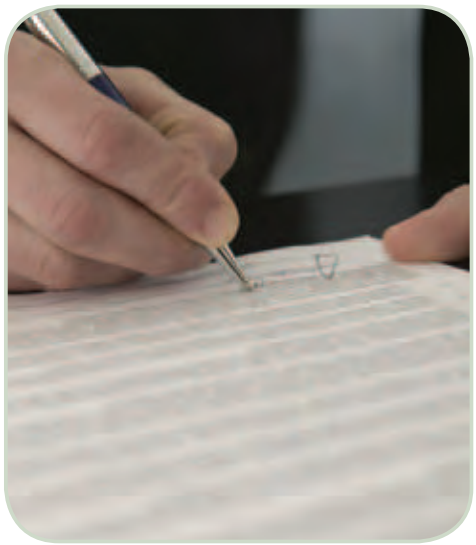
For More Information

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

"Contact Information," page 3; "Plan Administration," page 12

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, 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 or write to their Division of Technical Assistance and Inquiries office at, 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.



Claims and Appeals Procedures

The "How to File a Claim" section in this Summary Plan Description 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 Plan Administrator.**

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;
- 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. 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).

If you don't file an appeal within the required timeframe, you'll lose the right to file suit in federal court under ERISA. You cannot sue in federal court before 60 days after proof of loss was submitted. Your suit must be filed within three years from when proof of loss was required. 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 administrators are responsible for handling your claims and appeals. **For identification and addresses for the Claims Administrator and Appeals Administrator, see "Contact Information."**

"Contact Information," page 3

CLAIMS AND APPEALS PROCEDURES

Information and Consents Required From You

When you file a claim or appeal, you and 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 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.

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. Your claim is considered filed on the date that you contact the Claims Administrator and tell them you are making a claim.

The deadline for a decision on certain claims and appeals can be extended if the Plan Administrator determines that special circumstances require an extension of time for processing the claim. The Plan 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**, not business days. These deadlines can be extended by agreement between you and the Claims Administrator or Appeals Administrator.

Deadlines for Decisions on Benefit Claims

In general, the Claims Administrator must notify you of its decision on your claim within a reasonable time after the claim is received, but not longer than 90 days.

The deadline may be extended for up to 90 days if special circumstances beyond the control of the Plan exist. If the Claims Administrator needs to extend the deadline, you will be notified in writing before the initial determination deadline noted above. The notice will tell you why the extension is necessary and when the Claims Administrator expects to make a decision on your claim. The extended deadline cannot be later than 180 days after the original claim was received.

Denials of Claims

If any part of your claim is denied, you will be given a written or electronic notice that will include:

- The specific reason(s) for the denial;
- 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;
- An explanation of the appeals procedures, including time limits that apply; and
- A statement of your right to file a lawsuit in federal court under ERISA, if your claim is denied on final appeal.

Appealing a Denied Claim

If any part of your claim is denied, you can appeal that denial. Your appeal to the Appeals Administrator must be made **in writing** within 60 days of a claim denial. To expedite your appeal, please indicate in large letters at the top of your letter that your letter is an appeal.

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.

Review of Denied Claim on Appeal

The Appeals Administrator will reconsider any denied claim that you appeal by the deadline. The Appeals Administrator must consider all information provided by you, even if this information was not submitted or considered in the original claim decision.

Deadlines for Decisions on Appeal

The Appeals Administrator must make its decision on your appeal within a reasonable time after the appeal is received, but not longer than 60 days.

The deadline for a decision on an appeal may be extended (not to exceed 60 days from the 60-day initial determination deadline). If the Appeals Administrator needs to extend the deadline, you will be notified in writing before the initial determination deadline noted above. The notice will tell you why the extension is necessary and when the Appeals Administrator expects to make the decision on your claim.

Denials of Appeals

If any part of your claim is denied on appeal, you will be given a written or electronic notice that will include:

- The specific reason(s) for the denial;
- References to each of the specific provision(s) of the Plan on which the denial is based;
- A statement that you are entitled, upon request, to see all documents, records and other information relevant to your claim for benefits, and to get free copies of that information;
- A statement describing any further appeal procedures 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.

Authority of the Appeals Administrator to Make Final Binding Decisions on Appeal

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 Appeals Administrator decides in its sole discretion that the applicant is entitled to them. The determination of the Appeals Administrator on appeal will be final and binding.

ERISA Plan Information

The Plan is governed by a federal law — the Employee Retirement Income Security Act of 1974 (ERISA), as amended — and is subject to its provisions.

ConocoPhillips Group Universal Life Insurance Plan *(Commonly referred to as the Employee Executive Life Insurance Plan)*	
Type of Plan	Welfare benefit plan providing group universal life or group variable life insurance. Benefits under the Plan are provided under the terms and conditions of the Plan, and the insurance contract as determined by the Claims Administrator.
Plan Number	530
Plan Year and Fiscal Records	Jan. 1 – Dec. 31
Plan Funding/Sources of Contributions	Benefits are funded through insurance contracts. The costs are paid entirely by participating employees.
Group Number	MetLife 010294

Glossary

absolute assignment: The irrevocable transfer of all rights, title, interest and incidents of ownership, both present and future, of the assigned benefit to an individual or trustee.

active employee: An employee who's on the direct U.S. dollar payroll.

actively at work: Performing all of the usual and customary duties of your job at a place required by the employer.

annual pay: For group universal life insurance, pay means base salary.

Appeals Administrator: An entity that processes appeals regarding benefit claims.

beneficiary, beneficiary(ies): The person(s) or entity(ies) you designate to receive specific benefits in the event of your death. You must name your beneficiary(ies) on the form provided by the Claims Administrator or online on *hr.conocophillips.com* or *gvuleservice.metlife.com*.

Claims Administrator: The entity responsible for processing benefit claims and for any other functions as explained in this Summary Plan Description (SPD).

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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. The statement and any required physical exam must be provided at your expense.

family medical leave of absence (FMLA): FMLA leave is family or medical leave taken under the terms of the Family and Medical Leave Act of 1993 (as amended).

leave of absence: A direct U.S. dollar payroll 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 a leave of absence-Labor Dispute, the Company places an active employee on this leave for the time when he or she is not working due to a labor dispute. Generally, benefits are not available during the leave.

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

physician: A person who is legally licensed to practice medicine in the United States. A licensed practitioner will be considered a physician if:

- There's a federal or state law that applies to the Group Universal Life Insurance Plan, and that law requires that any service performed by such a practitioner must be considered for benefits on the same basis as if the service were performed by a physician; and
- The service performed by the practitioner is within the scope of his or her license.

plan year: The calendar year (Jan. 1 – Dec. 31).

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."

terminally ill: Certified by a physician as having a life expectancy, due to illness, of 12 months or less.

U.S. expatriate (expat): An employee on the direct U.S. dollar payroll working for the Company outside the United States on a temporary assignment and designated by the Company as a U.S. expatriate.

valid beneficiary designation: A Claims Administrator-approved form for this Plan that's signed, dated and received by the Claims Administrator or completed online on *hr.conocophillips.com* or *gvuleservice.metlife.com*.