ConocoPhillips

2013 Expatriate Benefit Highlights

Click Here for Prescription Drugs

Click Here for Dental Benefits

Click Here for Rates and Carrier Information

	Expatriate		
	Network (In the U.S.)	Non-Network (In the U.S.)	Outside the U.S.
Cost Sharing			
Annual deductible	$500 You Only coverage $1,500 Other coverage levels	$1,000 You Only coverage $3,000 Other coverage levels	None
Out-of-pocket maximum	$3,000 You Only coverage $6,000 Other coverage levels; deductible and copays not included	$5,000 You Only coverage $10,000 Other coverage levels; deductible and copays not included	None
Lifetime coverage limit	No limit	No limit	No limit
Preventive Care			
Annual physical exam	100% covered	60% after deductible	100% covered
Well-woman exam (includes pap)	100% covered	60% after deductible	100% covered
Mammogram	100% covered	60% after deductible	100% covered
Preventive colonoscopy	100% covered	60% after deductible	100% covered
Outpatient Care			
Primary doctor office visit	$25 copay	60% covered after deductible	100% covered
Specialist office visit	$50 copay	60% covered after deductible	100% covered
Outpatient surgery	80% covered after deductible	60% covered after deductible	100% covered
Outpatient laboratory services	80% covered after deductible	60% covered after deductible	100% covered
Outpatient physical therapy	80% covered after deductible	60% covered after deductible	100% covered
Outpatient X-ray	80% covered after deductible	60% covered after deductible	100% covered
Family Planning/Maternity			
Office visit: Pre/postnatal	$25 copay PCP; $50 copay specialist	60% covered after deductible	100% covered
In-hospital delivery services	$250 inpatient per confinement deductible; 80% covered after deductible	$250 inpatient per confinement deductible; 60% covered after deductible	100% covered
Fertility services	80% covered after deductible	60% covered after deductible	100% covered
Vision			
Routine vision exams	100% covered	60% covered after deductible	100% covered
Glasses and contacts	Aetna Vision Discounts	Not covered	Not covered

	Expatriate		
	Network (In the U.S.)	Non-Network (In the U.S.)	Outside the U.S.
Inpatient Care			
Inpatient physician and surgeon services	80% covered after deductible	60% covered after deductible	100% covered
Hospital semi-private room	80% covered after deductible and $250 inpatient per confinement deductible	60% covered after deductible and $250 inpatient per confinement deductible	100% covered
Emergency Care			
Emergency room	$100 copay then 80% covered after deductible	$100 copay then 80% covered after deductible	100% covered
Urgent care clinic visit	80% covered after deductible	80% covered after deductible	100% covered
Ambulance services	80% covered after deductible	80% covered after deductible	100% covered
Mental Health			
Mental Health: Outpatient coverage	$25 copay	60% covered after deductible	100% covered
Mental Health: Inpatient coverage	80% covered after deductible and $250 inpatient per confinement deductible	60% covered after deductible and $250 inpatient per confinement deductible	100% covered
Detox: Outpatient coverage	$25 copay	60% covered after deductible	100% covered
Detox: Inpatient coverage	80% covered after deductible and $250 inpatient per confinement deductible	60% covered after deductible and $250 inpatient per confinement deductible	100% covered
Rehab: Outpatient coverage	$25 copay	60% covered after deductible	100% covered
Rehab: Inpatient coverage	80% covered after deductible and $250 inpatient per confinement deductible	60% covered after deductible and $250 inpatient per confinement deductible	100% covered
Alternative Care			
Chiropractic	80% covered after deductible	60% covered after deductible	100% covered
Other			
Durable medical equipment	80% covered after deductible	60% covered after deductible	100% covered

Prescription Drugs

	Network in the U.S.	Outside the U.S.
Retail		
Retail generic	$10 copay per one month supply	Covered Under Medical
Retail formulary brand	60% covered; $25 minimum copay; $100 maximum copay per one month supply	Covered Under Medical
Retail nonformulary brand	50% covered; $50 minimum copay; $200 maximum copay per one month supply	Covered Under Medical
Mail Order		
Mail order generic	$10 copay for each 90 day supply	N/A
Mail order formulary brand	60% covered; $25 minimum copay; $100 maximum copay for each 90 day supply	N/A
Mail order nonformulary brand	50% covered; $50 minimum copay; $200 maximum copay for each 90 day supply	N/A

Dental Plan Features

Plan Limits	
Annual deductible	$50 You Only coverage $150 Other coverage levels
Waived for preventive	Yes
Annual plan maximum	$2,000
Lifetime orthodontia plan maximum	$1,500
Diagnostic and Preventive Services	**You Pay**
Diagnostic and preventive	100% covered
Oral exams	100% covered
Bitewing X-rays	100% covered
Full mouth X-rays	100% covered
Cleaning and scaling	100% covered
Prophylaxis treatments	100% covered
Fluoride treatments	100% covered
Space maintainers	100% covered
Sealants	100% covered

Basic Services	You Pay
Oral surgery	20% after deductible
Filings – Restorative: amalgam, synthetic porcelain and plastic restorative	20% after deductible
Endodontic treatment	20% after deductible
Periodontic treatment	20% after deductible
Major Services	**You Pay**
Crowns, jackets and cast restoration benefits	50% after deductible
Prosthodontic benefits (fixed bridges, partial/complete dentures)	50% after deductible
Implants	Not covered under Dental
Orthodontia Services	**You Pay**
Orthodontia	50%
Dependent children	Covered
Adults (and covered full-time students, if eligible)	Covered

Note: This is not evidence of coverage. You must enroll and be accepted for coverage with the Coverage Administrator before these documents will be effective. In the case of a discrepancy between the Plan Documents and this document, the Plan Documents will determine the Plan of Benefits. As used herein, the term "Plan Documents" includes, but is not limited to, the Booklet, Summary of Coverage and any Booklet Amendments/Riders including any state-specific variations, as applicable. For further details, refer to your Plan Documents.

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

2013 Expatriate Rates

100% Annualized Employee Cost			100% Annualized Company Cost			100% Annualized Total Cost		
You Only	You + 1	You + 2 or more	You Only	You + 1	You + 2 or more	You Only	You + 1	You + 2 or more
$1,204.08	$2,408.23	$3,612.31	$4,816.32	$9,632.93	$14,449.25	$6,020.40	$12,041.16	$18,061.56

Monthly Employee Cost		
You Only	You + 1	You + 2 or more
$100.34	$200.69	$301.03

Carrier Information

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