



Retiree Benefits Update

October 2010

AGENDA

- **U.S. Medical – Goals and Results**
- **A Businesslike Approach to Medical Costs**
- **Retiree Dental**
- **Pre-65 Retiree Medical and Rx Benefits**
 - **Controlling Costs and Managing Health**
 - **HDHP Medical Option with a Health Savings Account (HSA)**
 - **2010 - 2011 Changes**
- **Post-65 Retiree Benefits**
 - **Medicare Supplement Insurance Plans (A – N)**
 - Overview
 - 2011 Enrollment
 - **Medicare Part D Prescription Drug Plans**
 - Medicare Part D Prescription Drug Plan Changes
 - 2011 Enrollment
 - **Where to get more information**



U.S. Medical – Goals and Results

Goals of ConocoPhillips U.S. Medical Plan

- **Deliver effective medical benefits and plan designs which incentivize healthy behaviors and prudent health care choices (greater participant awareness of health risks and the costs of health care)**
- **Protect participants from catastrophic loss by limiting maximum annual out-of-pocket expenses**
- **Provide predictability in premiums; manage costs and liabilities**

2009 / 2010 Plan Results

- **Claims have been higher than premiums resulting in a depletion of reserves**
- **Catastrophic claims (over \$100k) were significantly higher than expected**
- **Migration to the consumer driven, High Deductible Health Plan, (HDHP) medical option has helped to offset these cost increases**

A Businesslike Approach to Medical Costs

- <http://www.youtube.com/watch?v=VnZOCj5Wnfg>
- <http://www.youtube.com/watch?v=pTKI0uFuUCQ>



United Healthcare Dental



- **4 dental plan options offered to ConocoPhillips retirees by UHC (2 high and 2 low, with and without implants)**
- **Plans are 100% retiree paid (\$32.73, \$35.58, \$41.84 \$42.68) and are priced per individual per month.**
- **Monthly premiums can be billed direct to retirees, automatically deducted from any bank account or paid by credit card.**
- **Request an enrollment kit by calling 1-800-996-7563, TTY:711, 8am to 8pm local time, 7 days a week.**

	<u>UHC High Dental Plan</u>	<u>UHC Low Dental Plan</u>
Annual Deductible	\$75	\$100
Annual Maximum	\$1,500	\$1,000
Diagnostic, Preventive, and Oral Exams	100%, no deductible	100% no deductible
Basic Dental Benefits	50% after deductible	50% after deductible
Oral Surgery	50% after deductible	50% after deductible
Endodontic Treatment	50% after deductible	50% after deductible
Periodontic Treatment	50% after deductible; Surgery: limit 1 every consecutive 36 months; Root Planning & Scaling: limit 1 per quadrant per consecutive 24 months; Maintenance: limit 2 per consecutive 12 months following active and adjunctive periodontal therapy, within the prior 24 months, exclusive of gross debridement	50% after deductible; Surgery: limit 1 every consecutive 36 months; Root Planning & Scaling: limit 1 per quadrant per consecutive 24 months; Maintenance: limit 2 per consecutive 12 months following active and adjunctive periodontal therapy, within the prior 24 months, exclusive of gross debridement
Implants	50% after deductible; limit 1 per 60 months (alternate benefits may be applied)	50% after deductible; limit 1 per 60 months (alternate benefits may be applied)

Pre-65 Retiree Medical and Prescription Drug Benefits



Tactics to Control Costs and Manage Health

- **Continue to encourage movement to consumer driven health care (HDHP) with goal of greater than 50% enrollment**
 - **Face-to-face retiree meetings reaching U.S. locations with large concentrations of retirees**
 - **New health care cost modeling tool uses participants' actual 2009 and 2010 year-to-date medical and prescription drug expenses to identify the most cost effective medical option**
- **Identify ineligible dependents and remove from medical and dental coverage**

What is Consumer Driven Health Care?

- Consumer Driven Health Care allows participants to use a **tax advantaged Health Savings Account (HSA) to pay health care expenses**, while a High Deductible Health Plan (HDHP) **protects participants from catastrophic medical expenses**
- **The HDHP medical option has a comparatively low monthly cost**, and participants can pay for routine medical claims using a pre-funded HSA. If the balance runs out, participants pay claims just like a regular deductible. Participants can also "rollover" unused balances in their HSA to invest for future medical expenses.
- This system of health care is referred to as "consumer driven health care" because **claims are paid using a consumer (participant) controlled account versus a fixed health insurance benefit**. This gives participants greater control over their health budgets and a decision-making role regarding health care
- Studies show HDHP participants are **twice** as likely as those in other medical options **to learn about costs and three times as likely to choose a less expensive treatment option, and chronic patients were 20 percent more likely to follow treatment**
- The high deductibles and out-of-pocket costs give participants an **incentive to learn about the costs and quality of care** before spending

HDHP: When you pay...and when you don't

Phase One: Preventive Care*	Phase Two: Meet your deductible	Phase Three: Meet your out-of-pocket maximum	Phase Four: The HDHP handles the rest
<ul style="list-style-type: none"> • <u>Preventive Network Medical Care</u> is covered at 100% per year (deductible waived) • <u>Certain Preventive Prescription Drugs</u> are covered at 100% up to \$1,500 per person per year (deductible waived) <p><i>* These amounts do not apply to your deductible.</i></p>	<ul style="list-style-type: none"> • You pay 100% of negotiated / discounted, covered medical & prescription drug costs, until you meet your deductible • All covered medical <u>& prescription drug costs</u> are applied to your deductible • <u>Certain Preventive Prescription Drugs</u>: you pay 20% after the \$1,500 allowance is met until you reach the out-of-pocket max <p>Annual Deductible: \$1,200 - "You only" \$2,400 - other coverage levels</p>	<ul style="list-style-type: none"> • You pay 20% of the negotiated / discounted costs for covered network care and prescription drugs (40% of cost for covered non-network care) until you reach the out-of-pocket max. • The HDHP pays 80% for covered network care and prescription drugs (60% for covered non-network care) • <u>Annual Out-of-Pocket Max.:</u> (amount includes deductible): <ul style="list-style-type: none"> • \$4,000 - "You only" • \$8,000 - other coverage levels 	<p>The plan pays 100% of covered medical services <u>and prescription drug costs</u> for the remainder of the calendar year</p>

How the HSA Works

Health Savings Account (HSA): a special savings account, owned by you, where contributions to the account help you pay for current and/or future medical expenses

Eligibility	Using the funds	Funding	Tax advantages
<p>Enrolled in HDHP</p> <ul style="list-style-type: none">• Pre-65 retirees must be enrolled in the HDHP• Can not be covered by any other medical option that is not a HDHP	<p>It's your money</p> <ul style="list-style-type: none">• Pay for eligible health care expenses directly from the account or reimburse yourself• Unused amounts roll over from year to year – there's <u>no</u> "use it or lose it" rule• The money is yours – you can take it with you and designate beneficiaries	<ul style="list-style-type: none">• You can contribute tax deductible funds to your HSA account• Total 2011 contributions can not exceed the IRS maximum of \$3,050 / \$6,150• If you are age 55 or older in 2011, you can make an additional contribution of up to \$1,000 to your account	<p>"Triple crown" federal tax savings</p> <ul style="list-style-type: none">• Tax deductible contributions• Tax-free earnings• Tax-free withdrawals when used for qualified medical expenses

U.S. Dependent Eligibility Verification (Audit)

- **Background**

- Currently participants self-certify the eligibility of dependents in the U.S. medical & dental plan
- There are over 36,000 dependents of U.S. employees / retirees in the Plan with average annual costs of \$3,740 / dependent

- **Steps Completed for Dependent Eligibility Verification**

- Strong communications via home mailings, newsletters and annual enrollment (AE) completed November 2009 – 1,322 dependent drops
- Communications and AE (Amnesty phases) resulted in a 4% drop in dependents resulting in an average annual savings of almost \$5 million
- Full dependent eligibility verification conducted by Hewitt; July 7 - August 6, 2010
- End of August: review list of employees / retirees with dependents scheduled to be dropped for extenuating business or personal situations
- September 1, 2010: Appeals process begins
- October 1, 2010: Final list of dependents dropped from coverage

- **Next Steps**

- Beginning January 1, 2011: all dependents added for medical coverage must provide documentation to support eligibility.
- First quarter of 2011 "gap" audit to include extenuating business or personal situations and 2011 AE dependent adds

2011 Pre-65 Retiree Premium Increases

Pre-65 Retiree Options	Rate Increase \$ / month	Participants (2010)	Comments
HDHP	24% / \$47	1,078 (31%)	HDHP continues to be the lowest cost option
PPO	25% / \$76	1,896 (55%)	Large catastrophic claims driving unfavorable experience
EPO	28% / \$122	421(12%)	Introduce a deductible and increase specialist copay to mitigate high utilization
Traditional Plan	29% / \$204	41 (<1%)	Eliminate this plan. It offers a poor economic choice for benefits which are exactly the same as provided for in other medical options

- The increase in the premiums is the result of unfavorable claims experience being spread over a relatively small pool (3,500 total participants) and the impact of the 4.5% cap on Company contributions
- The HDHP plan offers current PPO and EPO participants the opportunity to reduce premiums over 2010 levels
- The Government retiree reinsurance reimbursement, if received, would reduce premiums (implemented via a premium holiday)

Average Premium Increases with Hindsight

Year / Aggregate Rate Increase	2008	2009	2010	Proposed 2011
Actual	10.8%	9.8%	10.3%	18%
Corrected	17.1%	16.8%	13.6%	

- With the benefit of hindsight (significantly higher than forecast catastrophic claims), the corrected premiums would have been higher in 2008 – 2010
- The Company has made-up 100% of the difference in these costs over the last 3 years
- 2011 premiums reflect the make-up in retiree premiums
- Rates are based on 24 months of historical claims data. For example, 2009 rates were based on historical claims data from the last 9 months of 2007, 2008 and the first 3 months of 2009.

2011 Changes – Employees & Pre-65 Retirees

ConocoPhillips Initiated Medical and Rx Plan Changes	Rationale
Add a \$500 individual / \$1,500 family deductible to the EPO	Currently the EPO is the only plan without a deductible. Adding a deductible will incentivize prudent use.
Increase specialist copay in the PPO and EPO plans from \$35 to \$50	This helps control the cost of these plans and makes the cost sharing for a specialist visit comparable to the current cost sharing for a primary care visit
Increase maximum out-of-pocket amounts per prescription refill (from \$150 to \$200 at retail and from \$250 to \$400 at mail)	This change addresses drug inflation and competitive alignment
Double out-of-pocket maximum for participants injured in motor vehicle accidents not wearing a seat belt or a motorcycle helmet	The intent of this change is not to save money but to send the message that motor vehicle safety is important

2011 Changes – Employees & Pre-65 Retirees

Medical Plan Changes	Rationale
Treat Mental Health and Substance Abuse benefits the same as any other condition	Required to comply with Mental Health Parity
Eliminate the \$5 million lifetime maximum benefit	Required to comply with Health Care Reform (HCR)
Allow additional children up to the age of 26 to enroll in the plan	Required to comply with HCR
Forego health care reform grandfathering (e.g., remove annual maximums on preventive care)	<ul style="list-style-type: none">• Many required benefits which are protected by grandfathering are already in COP Plan• Other requirements must be included by 2014, grandfathering delays implementation

Pre-65 Retiree Questions

- **ConocoPhillips Benefits Center -**
 - **800-622-5501 or 718-354-1344**
 - Monday – Friday: 8:00 a.m. to 6:00 p.m. Central time
- <http://resources.hewitt.com/conocophillips>
- Online benefits information also available at <http://hr.conocophillips.com> (SPD's, Claim Forms, Benefit Highlights, DocFind, etc)

Post-65 Retirees - Medicare Supplement Insurance Plans



About AARP Medicare Supplement Insurance Plans

- **AARP Medicare Supplement Insurance Plans insured by UnitedHealthcare**
- **Medicare Supplement Insurance Plans (Plans A, B, C, F, K, L & N) available in most States**
- **New plans due to MIPPA – all retirees enrolled with AARP Medicare Supplement plans prior to June 1, 2010 were grandfathered into their current plan**
- **Customer service representatives specially trained to meet the needs of retirees and dependents age 65 and over; available Mon. – Fri. : 7 a.m. - 11 p.m. & Sat: 9 a.m. - 5 p.m. Eastern time at:**

1 – 800 – 568 – 6404



AARP Med Supp MIPPA Plans – June 2010 and Beyond

	Plan A	Plan B	Plan C	Plan F	Plan K	Plan L	Plan N
Annual Out of Pocket Max	None	None	None	None	\$4,640¹	\$2,320¹	None
Part A Coinsurance + 365 additional days after Medicare benefits end	x	x	x	x	x	x	x
Part A Deductible (\$1,100 in 2010)		x	x	x	50%	75%	x
Part B Coinsurance or Copayment	x	x	x	x	50%²	75%²	copay³
Part B Deductible (\$155 in 2010)			x	x			
Part B Excess Charges				x			
Blood - First 3 pints	x	x	x	x	50%	75%	x
Foreign-Travel Emergency (Up to plan limits)			x	x			x
Hospice Care Coinsurance or Copayment	x	x	x	x	50%	75%	x
Preventive Care Coinsurance	x	x	x	x	x	x	x
Skilled-Nursing Coinsurance			x	x	50%	75%	x

¹ 2010 Out-of-Pocket Maximum Amount Shown. After you meet your out-of-pocket yearly limit and your yearly Part B deductible (\$155 in 2010) the plan pays 100% of the covered services for the rest of the calendar year. Out-of-pocket limit is the maximum amount you would pay for the coinsurance and copayments.

² Plans K and L will pay 100% of Part B co-insurance for preventive services covered by Medicare.

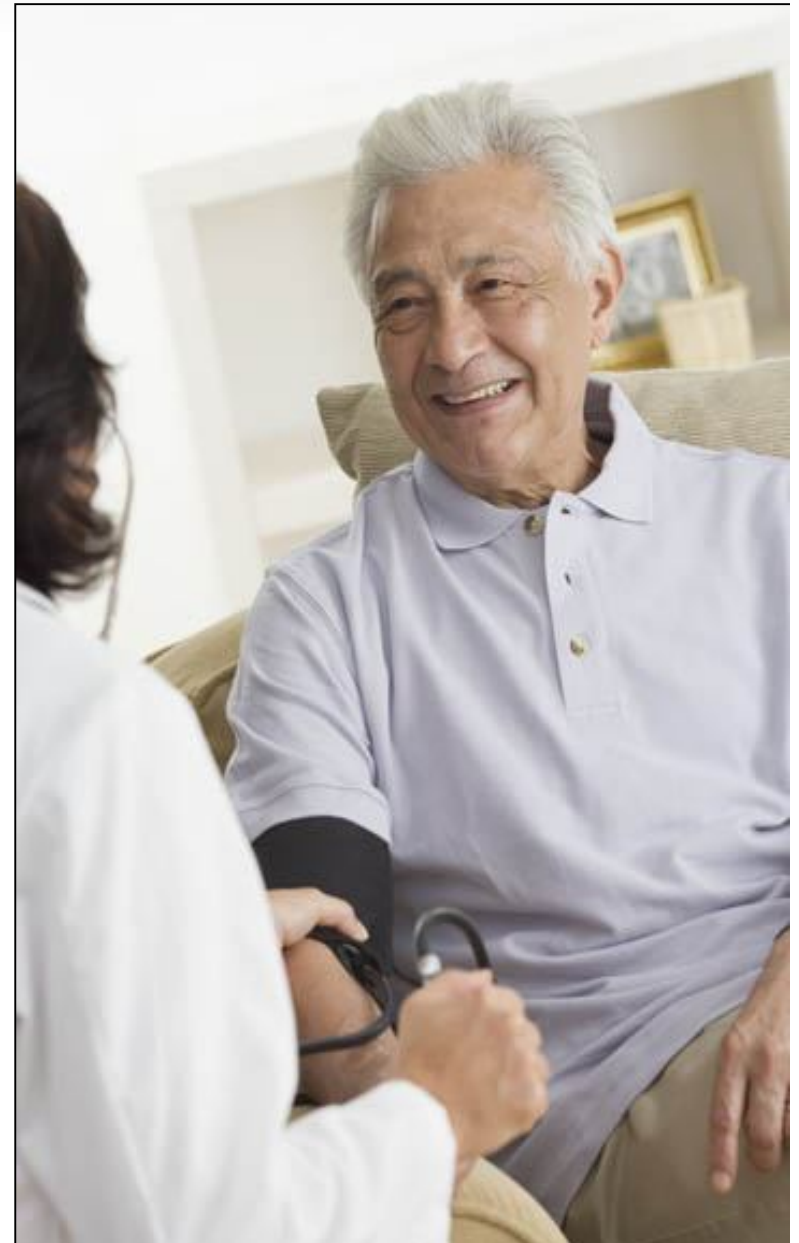
³ up to \$20 copay for office visits and up to \$50 copay for ER

What to Expect in 2011 – No Need to Re-Enroll!

- If you are happy with your current AARP Medicare Supplement Insurance Plan, you do not need to do anything for the new year
- Your 2010 election will automatically roll over for 2011 medical coverage
- Looking for more or less coverage, you can contact United Healthcare at anytime to change plans. Remember plan changes will become effective the first of the following month

Reminder of the dedicated ConocoPhillips
phone number:

1 – 800 – 568 – 6404



What to Expect and When to Expect it

AARP Medicare Supplement Insurance Plans

2011 Premium Bill

- In mid-October you will receive the annual premium notification letter for your AARP Medicare Supplement monthly plan premium for 2011
- The amounts shown in this letter will have already taken your ConocoPhillips subsidy and any applicable discounts (i.e. EFT) into account
- You only will see the net amount for your household (i.e. you and your spouse)

Annual Premium Notification Letter #1

Version # 1 for:

Retirees who **DO NOT** have a remaining monthly premium balance after the COP subsidy contribution

2011 Plan and Payment Information

At this time, payments for your plan(s) are being made by your former employer or organization. Please see the back of this letter for a chart of those monthly payments, your plan(s) and rate(s).

If you share the cost of your insurance with your employer, please make your payments as you do now, unless they notify you of a change. In the unlikely event your employer does not make a payment on your behalf, you will be responsible for making the payment to keep your coverage active. If this happens, we will let you know as soon as possible so you can make payment arrangements.

Amount to be paid by your employer

If you share the cost of your insurance with your employer, please make your payments as you do now. The **AMOUNT DUE** is the total household premium including all of your discounts and adjustments.

DUE DATE	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE
AMOUNT DUE	(Jan Prem)	(Feb Prem)	(Mar Prem)	(Apr Prem)	(May Prem)	(Jun Prem)
DUE DATE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
AMOUNT DUE	(Jul Prem)	(Aug Prem)	(Sept Prem)	(Oct Prem)	(Nov Prem)	(Dec Prem)

The amounts shown will be full amounts that COP is billed.

You do not owe this amount.

Annual Premium Notification Letter #2

Version # 2 for:

Retiree who have a monthly premium remaining after the COP subsidy contribution.

How much you owe

These amounts will be automatically withdrawn from your bank account in the months shown. The **AMOUNT DUE** is the total household premium including all of your discounts and adjustments.

DUE DATE	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE
AMOUNT DUE	(Jan Prem)	(Feb Prem)	(Mar Prem)	(Apr Prem)	(May Prem)	(Jun Prem)
DUE DATE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
AMOUNT DUE	(Jul Prem)	(Aug Prem)	(Sept Prem)	(Oct Prem)	(Nov Prem)	(Dec Prem)

- Your household amount due with any applicable discounts and ConocoPhillips subsidy amounts applied.
- If you are currently paying via coupon book, the letter will indicate your payment method and you will be sent a new coupon book.

Choosing the right Medicare Part D Plan for YOU!



Health Care Reform – Enhancements to Medicare Part D Prescription Drug Plans

Enhancements to post-65 retiree standard prescription drug plans as a result of health care reform include:

- In the donut hole, during 2010 participants received a \$250 rebate check to help with expenses
- In the donut hole, beginning in 2011, 50% discount on brand prescriptions; prior to 2011 no coverage available
- In the donut hole, beginning in 2011, coverage for generic prescriptions; prior to 2011 no coverage available

2011 Changes - AARP Medicare Part D Prescription Drug Plans

- **AARP Saver Plan will be eliminated as of January 1, 2011 due to Health Care Reform**
- **Any retiree currently enrolled in the Saver Plan will be automatically enrolled in the AARP Preferred Plan unless they reside in NY, CA and FL**
- **Specific plan designs and premium information will be mailed to all COP retirees by October 31, 2010 so you have enough time to make an informed decision**
- **There will be formulary changes to the 2011 Preferred Plan. Many brand medications will only be available in the generic equivalent form.**
- **All retirees will receive at least 7% coverage for generics and 50% coverage for brand medications while in the coverage gap. The percentage covered will be based on contracted rate, not full retail.**

2011 Preferred & Enhanced Rx Plans for Texas

		AARP MedicareRx Preferred	AARP MedicareRx Enhanced
	Plan Type	Basic (Preferred) Alternative	Enhanced Alternative
	Formulary <ul style="list-style-type: none"> ▪ Drugs covered ▪ Formulary ID 	Formulary C <ul style="list-style-type: none"> • 76% (many medications will only be available in generic equivalent form) 	Formulary A <ul style="list-style-type: none"> • 99%
Phase I (Deductible)	Deductibles	\$0	\$0
Phase II Initial Coverage Limit	Copays for a one-month supply - Texas	Tier 1: \$7 Tier 2: \$45 Tier 3: \$71 Tier 4: 33%	Tier 1: \$4 Tier 2: \$40 Tier 3: \$75 Tier 4: 33%
	Copays for Preferred Mail service 90-day supply - Texas	Tier 1: \$7 Tier 2: \$120 (3x retail - \$15) Tier 3: \$198 (3x retail - \$15) Tier 4: 33%	Tier 1: \$8 Tier 2: \$105 (3x retail - \$15) Tier 3: \$210 (3x retail - \$15) Tier 4: 33%
Phase III Coverage Gap		50% discount on brands (non-LICS) 93% coinsurance on generics (non-LICS)	Tier 1: gap coverage: \$4 retail (31 days) Tiers 2 - 4: 50% discount on brands (non-LICS)
Phase IV Catastrophic Coverage		Greater of 5% of drug cost, or \$2.50 for generics and \$6.30 for brands.	Greater of 5% of drug cost, or \$2.50 for generics and \$6.30 for brands.

Where Else Can I Find Information?

- Read the *Medicare & You* handbook which is mailed to you each year in October
- The *State Health Insurance Assistance Program* (SHIP) is a counseling program available to assist the public with Medicare and senior health insurance issues. Links to your state's SHIP Web site are provided on www.medicare.gov.
- Call 800-MEDICARE (800-633-4227) and say "Agent"
- Contact your local pharmacy and see if they can assist you with comparing Medicare Part D Prescription Drug Plans for your individual prescription needs
- Visit the Administration on Aging Web site at www.aoa.gov to learn more about local programs

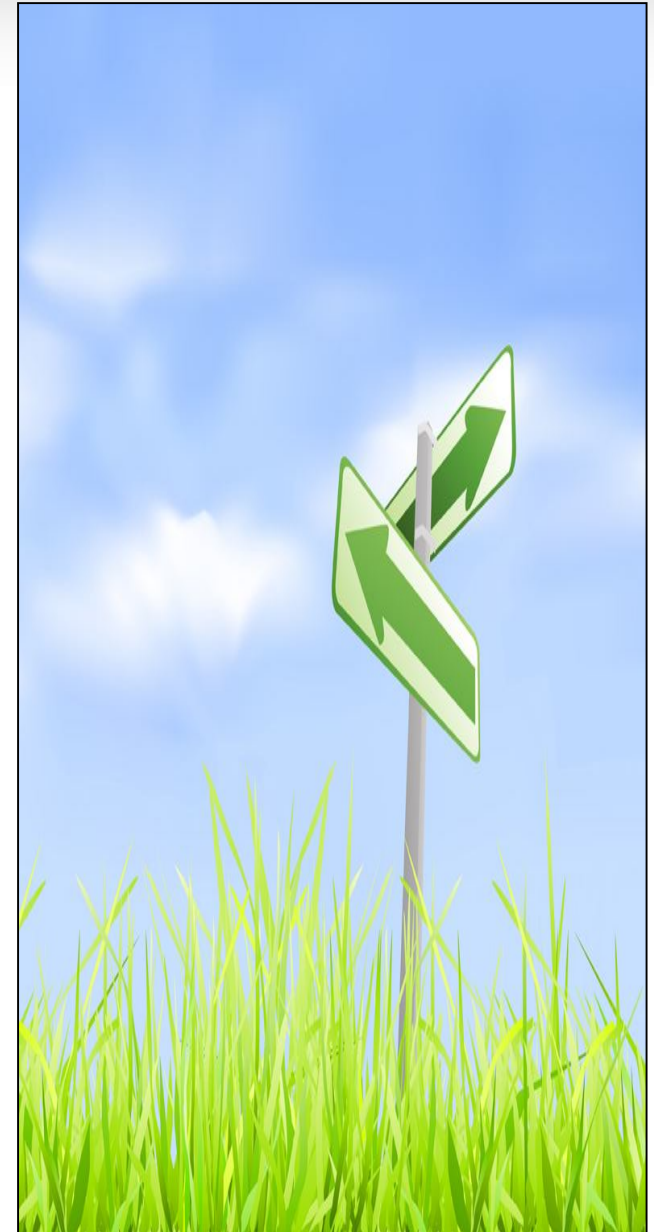
When Do I Enroll in a Medicare Part D Prescription Drug Plan?

- Joining a Medicare Part D Prescription Drug Plan when you are first eligible means you won't have to pay a late enrollment penalty. Every year (between Nov. 15–Dec. 31), you can enroll or switch to a different Medicare Part D Prescription Drug Plan.
- We encourage you to enroll as soon as possible after Nov. 15 so you will receive your membership materials before Jan. 1 to avoid any inconvenience at the pharmacy

Next Steps

- **If you are happy with your current United Healthcare Medicare Supplement Insurance Plan (A – N) or Medicare Part D Prescription Drug Plan you do not need to do anything for 2011.**
- **Not enrolled yet or want to make changes?**
 - **You may change your Medicare Supplement Insurance Plan at any time.**
 - **Your Medicare Part D Prescription Drug Plan changes or new enrollment will take place only during open enrollment November 15 - December 31st**
- **Don't forget to review what Medicare Part D Prescription Drug Plan is right for YOU!**
- **Ask questions now and in the future by calling United Healthcare at:**

1 – 800 – 568 – 6404



Disclaimer

This presentation is intended to be accurate, but if there is any discrepancy between these materials or the presentation and the terms of the official plan documents, the official plan documents will control. In addition, although ConocoPhillips intends to continue these benefit plans indefinitely, the company reserves the right to amend, change or terminate any of these benefit plans or provisions at any time.

You are not required to use the plan's Preferred Mail Service Pharmacy to obtain a supply of your maintenance medications. You have the option of using the Preferred Mail Service Pharmacy, a retail extended day supply pharmacy or non-preferred mail service pharmacy in the network to obtain a supply of maintenance medications.

If you choose a retail extended day supply pharmacy or non-preferred mail service pharmacy, you may see out-of-pocket payment differences when compared to using the Preferred Mail Service Pharmacy. You should experience no out-of-pocket payment differences if choosing between a retail extended day supply pharmacy and a non-preferred mail service pharmacy. Please call UnitedHealthcare Customer Care, 24 hours a day, 7 days a week for up-to-date information on which pharmacies are in the network.

Your prescriptions should arrive in about seven days from the date the completed order is received by Prescription Solutions. If Prescription Solutions needs to contact you or your prescribing physician to clarify information on your order or to request prescriptions from your physician, delivery may take longer. If you prefer rush delivery, medications can be shipped overnight for an additional charge. You should fill your prescriptions locally if you are out of your medications and cannot wait for your mail order prescriptions to arrive. Standard delivery is no charge to U.S. addresses, including U.S. territories.

For copay amounts, drug coverage information or general plan questions, please call UnitedHealthcare Customer Care at 1-800-545-1797, 24 hours a day, 7 days a week, TTY/TDD 1-877-730-4192.

Prescription Solutions is an affiliate of United HealthCare Insurance Company and United HealthCare Insurance Company of New York.

These Medicare Prescription Drug Plans (PDPs) are insured by United HealthCare Insurance Company or United HealthCare Insurance Company of New York for New York residents (together called "UnitedHealthcare"). AARP MedicareRx Plans carry the AARP name, and UnitedHealthcare pays a fee to AARP and its affiliate for use of the AARP trademark and other services. Amounts paid are used for general purposes of AARP and its members. AARP is not the insurer. UnitedHealthcare receives rebates from drug manufacturers that it passes on to its enrollees through reductions in premiums and to Medicare to reduce Medicare program costs. UnitedHealthcare contracts with the Federal government as a PDP sponsor. All decisions about prescription drugs are between you and your physician or other health care provider.

AARP does not make prescription drug plan recommendations for individuals. You are strongly encouraged to evaluate your needs before choosing a prescription drug plan.

You must continue to pay your Medicare Part B premium if not otherwise paid for under Medicaid or by another third party.