The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, log onto hr.phillips66.com or call 1-800-965-4421. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-965-4421 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $800 you only/$1,600 family. Non-network: $1,600 you only/$3,200 family. Network and non-network combined; excludes medical copays and prescription drug costs.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $5,000 individual/$10,000 family. Non-network: $15,000 individual/$30,000 family.	The out-of-pocket limit is the most you can pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Expenses not covered by the plan, such as expenses in excess of non-network reimbursement rate limits (typically referred to as usual customary and reasonable), precertification penalties, premiums, balance billed charges, prescription drug retail refill allowance, quantity level limitations, brand/ generic difference.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.bcbstx.com or call 1-855-594-4233 for a list of medical and behavioral health network providers. See www.caremark.com or call 1-888-208-9634 for a list of prescription drug network providers.	This plan uses a provider network. You will generally pay less if you use a provider in the plan's network. You will generally pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copayment	50% coinsurance, after deductible	Copay not applicable to the deductible.
	Specialist visit	$60 copayment	50% coinsurance, after deductible	Copay not applicable to the deductible.
	Preventive care/screening/ immunization	Plan pays 100% preventive care.	Plan pays 100% of first $1,000 preventive care per calendar year, then 50% coinsurance. No deductible	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance, after deductible	50% coinsurance, after deductible	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance, after deductible	50% coinsurance, after deductible	Precertification required for certain procedures.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com or call 1-888-208-9634.	Generic drugs	Retail: $10 copayment Mail: $25 copayment	Retail: 50% coinsurance. Mail: N/A	Non-network retail: You pay amounts above the negotiated/discounted rate.
	Preferred brand drugs	Retail: 35% coinsurance Mail: 35% coinsurance	Retail: 50% coinsurance. Mail: N/A (See Limitations & Exclusions)	Network retail: $150 maximum. Non-network retail: You pay coinsurance plus amount above negotiated/discounted rate. Mail: $300 maximum.
	Non-preferred brand drugs	Retail: 50% coinsurance Mail: 50% coinsurance	Retail: 50% coinsurance. Mail: N/A (See Limitations & Exclusions)	Network retail: $300 maximum. Non-network retail: You pay coinsurance plus amount above negotiated/discounted rate. Mail: $600 maximum.
	Specialty drugs	N/A	N/A	Check with plan. Infertility medications limited to $10,000 per lifetime, per person
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance, after deductible	50% coinsurance, after deductible	Check with plan.
	Physician/surgeon fees	20% coinsurance, after deductible	50% coinsurance, after deductible	
If you need immediate medical attention	Emergency room care	20% coinsurance, after deductible	20% coinsurance, after deductible	50% coinsurance for non-emergency use of ER; both network/non-network.
	Emergency medical transportation	20% coinsurance, after deductible	20% coinsurance, after deductible	None
	Urgent care	$60 copayment	50% coinsurance, after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance, after deductible	50% coinsurance, after deductible	Precertification required for non-network. $200 penalty applies. Check with plan.
	Physician/surgeon fees	20% coinsurance, after deductible	50% coinsurance, after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copayment for office visit; 20% coinsurance for other services, after deductible	50% coinsurance, after deductible	Precertification required for non-network inpatient services. $200 penalty may apply. Check with plan.
	Inpatient services	20% coinsurance, after deductible	50% coinsurance, after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$30 copayment for PCP; $60 copayment for specialist	50% coinsurance, after deductible	Imaging and laboratory services subject to normal plan benefits. Services outside this care are subject to normal plan benefits. Check with plan.
	Childbirth/delivery professional services	20% coinsurance, after deductible	50% coinsurance, after deductible	Check with plan.
	Childbirth/delivery facility services	20% coinsurance, after deductible	50% coinsurance, after deductible	Check with plan.
If you need help recovering or have other special health needs	Home health care	20% coinsurance, after deductible	50% coinsurance, after deductible	Reduced coverage may apply; check with plan.
	Rehabilitation services	20% coinsurance, after deductible	50% coinsurance, after deductible	Reduced coverage may apply; check with plan.
	Habilitation services	20% coinsurance, after deductible	50% coinsurance, after deductible	Reduced coverage may apply; check with plan.
	Skilled nursing care	20% coinsurance, after deductible	50% coinsurance, after deductible	Reduced coverage may apply; check with plan.
	Durable medical equipment	20% coinsurance, after deductible	50% coinsurance, after deductible	Reduced coverage may apply; check with plan.
	Hospice services	20% coinsurance, after deductible	50% coinsurance, after deductible	Reduced coverage may apply; check with plan.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	See Vision Plan
	Children's glasses	Not covered	Not covered	See Vision Plan
	Children's dental check-up	Not covered	Not covered	See Dental Plan

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care
- Hearing aids
- Infertility treatment
- Private duty nursing
- Routine foot care

* For more information about limitations and exceptions, see the plan document at hr.phillips66.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-800-965-4421 or visit us at hr.phillips66.com.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-965-4421.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-965-4421.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-965-4421.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-965-4421.

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

* For more information about limitations and exceptions, see the plan document at hr.phillips66.com.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$800
Specialist copayment	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$800
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,270

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$800
Specialist copayment	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$500
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,420

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$800
Specialist copayment	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$800
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,300

The plan would be responsible for the other costs of these EXAMPLE covered services.