**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.<br>**Non-network: $1,600** you only/**$3,200** family.<br>Network and non-network combined; excludes medical copays and prescription drug costs.<br>Does not apply to preventive care. | 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.<br>**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. Once an individual out-of-pocket limit has been met, covered services for that individual are paid at 100%. 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 | Copay not applicable to the deductible. |
| | Specialist visit | $60 copayment | 50% coinsurance | Copay not applicable to the deductible. |
| | Preventive care/screening/ immunization | No charge | 50% coinsurance | **Network:** Plan pays 100% preventive care. **Non-network:** Plan pays 100% of first $1,000 preventive care per calendar year. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% coinsurance | 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.<br><br>Infertility medications limited to $10,000 per lifetime, per person. | Generic drugs | Retail: $10 copayment<br>Mail: $25 copayment | Retail: 50% coinsurance.<br>Mail: N/A | **Non-network retail:** You pay amounts above the negotiated/discounted rate. |
| | Preferred brand drugs | Retail: 35% coinsurance<br>Mail: 35% coinsurance | Retail: 50% coinsurance.<br>Mail: N/A<br>(See Limitations & Exclusions) | **Network retail:** $150 maximum.<br>**Non-network retail:** You pay coinsurance plus amount above negotiated/discounted rate.<br>**Mail:** $300 maximum. |
| | Non-preferred brand drugs | Retail: 50% coinsurance<br>Mail: 50% coinsurance | Retail: 50% coinsurance.<br>Mail: N/A<br>(See Limitations & Exclusions) | **Network retail:** $300 maximum.<br>**Non-network retail:** You pay coinsurance plus amount above negotiated/discounted rate.<br>**Mail:** $600 maximum. |
| | Specialty drugs | N/A | N/A | Check with plan. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | Reduced coverage may apply for certain procedures; check with plan. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | 20% coinsurance | 50% coinsurance for non-emergency use of ER; both network/non-network. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | None |
| | Urgent care | $60 copayment | 50% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance | Precertification required for non-network. $200 penalty applies. Reduced coverage may apply for certain procedures; check with plan. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $30 copayment for office visit;<br>20% coinsurance for other services | 50% coinsurance | Precertification required for non-network inpatient services. $200 penalty may apply. Reduced coverage may apply for certain procedures; check with plan. |
| | Inpatient services | 20% coinsurance | 50% coinsurance | |

| 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 | 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 | 50% coinsurance | Check with plan. |
| | Childbirth/delivery facility services | 20% coinsurance | 50% coinsurance | Check with plan. |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 50% coinsurance | Reduced coverage may apply; check with plan. |
| | Rehabilitation services | 20% coinsurance | 50% coinsurance | Reduced coverage may apply; check with plan. |
| | Habilitation services | 20% coinsurance | 50% coinsurance | Reduced coverage may apply; check with plan. |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | Reduced coverage may apply; check with plan. |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | Reduced coverage may apply; check with plan. |
| | Hospice services | 20% coinsurance | 50% coinsurance | Reduced coverage may apply; check with plan. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | None |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | None |

## 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** | **$12,840** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $800 |
| Copayments | $100 |
| Coinsurance | $2,480 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,440** |

### 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** | **$7,460** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $800 |
| Copayments | $670 |
| Coinsurance | $1,630 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$3,160** |

### 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** | **$2,010** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $800 |
| Copayments | $180 |
| Coinsurance | $330 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,310** |

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