




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](http://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/](http://www.healthcare.gov/sbc-glossary/) or call 1-800-965-4421 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p><b>Network: \$800</b> you only/<b>\$1,600</b> family.  <b>Non-network: \$1,600</b> you only/<b>\$3,200</b> family.                      Network and non-network combined; excludes medical copays and prescription drug costs.                      Does not apply to preventive care.</p>	<p>If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. Preventive care.</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p><b>Network: \$5,000</b> individual/<b>\$10,000</b> family.  <b>Non-network: \$15,000</b> individual/<b>\$30,000</b> family.</p>	<p>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 <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p>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.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.aetna.com">www.aetna.com</a> or call 1-855-267-4184 for a list of medical and behavioral health network providers. See <a href="http://www.caremark.com">www.caremark.com</a> or call 1-888-208-9634 for a list of prescription drug network providers.	This <a href="#">plan</a> uses a provider network. You will generally pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will generally pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your plan pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 copayment	50% coinsurance	Copay not applicable to the deductible.
	<a href="#">Specialist</a> visit	\$60 copayment	50% coinsurance	Copay not applicable to the deductible.
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% coinsurance	<b>Network:</b> Plan pays 100% preventive care. <b>Non-network:</b> Plan pays 100% of first \$1,000 preventive care per calendar year.
If you have a test	<a href="#">Diagnostic test</a> (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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a> or call 1-888-208-9634.  Infertility medications limited to \$10,000 per lifetime, per person.	Generic drugs	Retail: \$10 copayment Mail: \$25 copayment	Retail: 50% coinsurance. Mail: N/A	<b>Non-network retail:</b> 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)	<b>Network retail:</b> \$150 maximum. <b>Non-network retail:</b> You pay coinsurance plus amount above negotiated/discounted rate. <b>Mail:</b> \$300 maximum.
	Non-preferred brand drugs	Retail: 50% coinsurance Mail: 50% coinsurance	Retail: 50% coinsurance. Mail: N/A (See Limitations & Exclusions)	<b>Network retail:</b> \$300 maximum. <b>Non-network retail:</b> You pay coinsurance plus amount above negotiated/discounted rate. <b>Mail:</b> \$600 maximum.
	<a href="#">Specialty drugs</a>	N/A	N/A	Check with plan.
<b>If you have outpatient surgery</b>	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	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% coinsurance	20% coinsurance	50% coinsurance for non-emergency use of ER; both network/non-network.
	<a href="#">Emergency medical transportation</a>	20% coinsurance	20% coinsurance	None
	<a href="#">Urgent care</a>	\$60 copayment	50% coinsurance	None
<b>If you have a hospital stay</b>	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
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$30 copayment for office visit; 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	

\* For more information about limitations and exceptions, see the plan document at [hr.phillips66.com](http://hr.phillips66.com).

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)	
<b>If you are pregnant</b>	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.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% coinsurance	50% coinsurance	Reduced coverage may apply; check with plan.
	<a href="#">Rehabilitation services</a>	20% coinsurance	50% coinsurance	Reduced coverage may apply; check with plan.
	<a href="#">Habilitation services</a>	20% coinsurance	50% coinsurance	Reduced coverage may apply; check with plan.
	<a href="#">Skilled nursing care</a>	20% coinsurance	50% coinsurance	Reduced coverage may apply; check with plan.
	<a href="#">Durable medical equipment</a>	20% coinsurance	50% coinsurance	Reduced coverage may apply; check with plan.
	<a href="#">Hospice services</a>	20% coinsurance	50% coinsurance	Reduced coverage may apply; check with plan.
<b>If your child needs dental or eye care</b>	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

**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](http://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](http://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](http://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](http://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, kwijijigo holne' 1-800-965-4421.

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

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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*)

<b>Total Example Cost</b>	<b>\$12,840</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$100
Coinsurance	\$2,480
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,440</b>

**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*)

<b>Total Example Cost</b>	<b>\$7,460</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$670
Coinsurance	\$1,630
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$3,160</b>

**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*)

<b>Total Example Cost</b>	<b>\$2,010</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$180
Coinsurance	\$330
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,310</b>