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 and costs, review the Intel Pay Stock and Benefits Handbook (the official plan document) in the Medical Plans chapter or call The Intel Health Benefits center at 1-877-466-9236. 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.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-866-444-EBSA (3272) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,600** Individual **$3,200** EE+Child(ren) **$4,000** Family	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, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	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 deductible for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	Yes. **$2,240** individual **$4,480** EE+Child(ren) **$5,335** family for in-and out-of-network providers.	The out-of-pocket limit is the most you could 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?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.phs.org or call 1-855-780-7737 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will 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	This plan will pay some or all of the costs to see a specialist for covered services. You can see the specialist you choose without permission from this plan.

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	5% coinsurance deductible applies	40% coinsurance deductible applies	None
	Specialist visit	5% coinsurance deductible applies	40% coinsurance deductible applies	None
	Preventive care/screening/ immunization	No charge deductible does not apply	40% coinsurance deductible applies	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	5% coinsurance deductible applies	40% coinsurance deductible applies	None
	Imaging (CT/PET scans, MRIs)	5% coinsurance deductible applies	40% coinsurance deductible applies	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	5% coinsurance deductible applies	40% coinsurance deductible applies	Covers up to a 30-day supply (retail subscription); 31-90-day supply (mail order prescription)
	Preferred brand drugs	5% coinsurance deductible applies	40% coinsurance deductible applies	
	Non-preferred brand drugs	5% coinsurance deductible applies	40% coinsurance deductible applies	
	Specialty drugs	5% coinsurance deductible applies	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance deductible applies	40% coinsurance deductible applies	None
	Physician/surgeon fees	5% coinsurance deductible applies	40% coinsurance deductible applies	
If you need immediate medical attention	Emergency room care	5% coinsurance deductible applies	5% coinsurance deductible applies	Copayment is waived if admitted into a Hospital, then Hospital copayment will apply.
	Emergency medical transportation	5% coinsurance deductible applies	5% coinsurance deductible applies	None
	Urgent care	5% coinsurance deductible applies	40% coinsurance deductible applies	None

*For more information about limitations and exceptions, see the plan or policy document: The Intel Stock Pay and Benefits Handbook (the official plan document).

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 have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance deductible applies	40% coinsurance deductible applies	None
	Physician/surgeon fees	5% coinsurance deductible applies	40% coinsurance deductible applies	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	5% coinsurance deductible applies	40% coinsurance deductible applies	None
	Inpatient services	5% coinsurance deductible applies	40% coinsurance deductible applies	None
If you are pregnant	Office visits	0% coinsurance after deductible has been met	40% coinsurance deductible applies	None
	Childbirth/delivery professional services	0% coinsurance after deductible has been met	40% coinsurance deductible applies	None
	Childbirth/delivery facility services	5% coinsurance deductible applies	40% coinsurance deductible applies	None
If you need help recovering or have other special health needs	Home health care	5% coinsurance deductible applies	40% coinsurance deductible applies	Prior authorization may be required.
	Rehabilitation services	5% coinsurance deductible applies	40% coinsurance deductible applies	None
	Habilitation services	5% coinsurance deductible applies	40% coinsurance deductible applies	None
	Skilled nursing care	5% coinsurance deductible applies	40% coinsurance deductible applies	Coverage is limited to 100 visits/year for Out-of-network services
	Durable medical equipment	5% coinsurance deductible applies	40% coinsurance deductible applies	None
	Hospice services	5% coinsurance deductible applies	40% coinsurance deductible applies	None
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

*For more information about limitations and exceptions, see the plan or policy document: The Intel Stock Pay and Benefits Handbook (the official plan document).

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.)

- Dental Care (Adult/Child)
- Weight loss programs
- Glasses (Child)
- Long Term Care
- Cosmetic surgery
- Private Duty Nursing
- Routine eye care (Adult/Child)
- Routine Foot Care

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

- Acupuncture (if prescribed for rehabilitation)
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Chiropractic Care
- Most coverage provided outside the United States. See www.phs.org
- Bariatric surgery

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: visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at http://www.dol.gov/ebsa or call their toll-free number at **1-866-444-3272**. You can also contact the Intel Health Benefits Center at (877) GoMyBen with questions. 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 on how 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: The Intel Health Benefits center at 1-877-466-9236.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, Essential Coverage, you may not be eligible for the premium tax credit.

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 1-877-466-9236.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-466-9236.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-466-9236.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-466-9236.

Learn more about Presbyterian's Notice of Nondiscrimination, go to www.phs.org/nondiscrimination.aspx.

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 or policy document: The Intel Stock Pay and Benefits Handbook (the official plan document).

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	$1600
Specialist	5%
Hospital (facility)	5%
Other	5%

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	**$10,640**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,160**

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

The plan's overall deductible	$1600
Specialist	5%
Hospital (facility)	5%
Other	5%

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	**$3,980**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

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

The plan's overall deductible	$1600
Specialist	5%
Hospital (facility)	5%
Other	5%

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	**$1,330**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,570**

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