




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, 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 <https://www.healthcare.gov/glossary/> or call 1-877-466-9236 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In network \$0 Out-of-network \$250 Individual \$750 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 ?	\$1,500 individual/ \$3,000 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	\$10 copayment /visit deductible does not apply	40% coinsurance deductible applies	None
	Specialist visit	\$25 copay /visit deductible does not apply	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)	No charge deductible does not apply	40% coinsurance deductible applies	None
	Imaging (CT/PET scans, MRIs)	No charge deductible does not apply	40% coinsurance deductible applies	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://client.formularynavigator.com/Search.aspx?siteCode=0322075909	Generic drugs	\$10 copay /prescription (retail) & \$20 copay prescription (mail order) deductible does not apply	40% coinsurance deductible applies	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	\$20 copay /prescription (retail) & \$50 copay prescription (mail order) deductible does not apply	40% coinsurance deductible applies	
	Non-preferred brand drugs	\$35 copay /prescription (retail) & \$105 copay prescription (mail order) deductible does not apply	40% coinsurance deductible applies	
	Specialty drugs	Generic - \$10 Brand - \$20 Non-preferred - \$35 copayment /prescription (retail) Not Covered (mail order) deductible does not apply	Not Covered	Specialty drugs may be mandated to Specialty Pharmacy; Coverage is limited up to a 30-day supply (retail prescription); Not Covered (mail order prescription)

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 copayment deductible does not apply	40% coinsurance deductible applies	None
	Physician/surgeon fees	No charge deductible does not apply	40% coinsurance deductible applies	
If you need immediate medical attention	Emergency room care	\$100 copayment /visit deductible does not apply	\$100 copayment /visit deductible does not apply	Copayment is waived if admitted into a Hospital, then Hospital copayment applies.
	Emergency medical transportation	No charge deductible does not apply	No charge deductible does not apply	None
	Urgent care	\$50 copayment /visit deductible does not apply	40% coinsurance deductible applies	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 copayment /admission deductible does not apply	40% coinsurance deductible applies	\$500 penalty may apply if Prior Authorization is not obtained for Out-of-Network services.
	Physician/surgeon fees	No charge deductible does not apply	40% coinsurance deductible applies	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 copayment /office visit deductible does not apply	40% coinsurance deductible applies	None
	Inpatient services	\$250 copayment /admission deductible does not apply	40% coinsurance deductible applies	
If you are pregnant	Office visits	\$25 copayment /initial visit only deductible does not apply	40% coinsurance deductible applies	None
	Childbirth/delivery professional services	No Charge deductible does not apply	40% coinsurance deductible applies	
	Childbirth/delivery facility services	\$250 copayment /admission deductible does not apply	40% coinsurance 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 need help recovering or have other special health needs	Home health care	No charge deductible does not apply	40% coinsurance deductible applies	None
	Rehabilitation services	\$10 copayment /visit per day deductible does not apply	40% coinsurance deductible applies	None
	Habilitation services	\$10 copayment /visit deductible does not apply	40% coinsurance deductible applies	None
	Skilled nursing care	\$250 copayment /admission deductible does not apply	40% coinsurance deductible applies	Coverage is limited to 100 days for out-of-network providers.
	Durable medical equipment	No charge deductible does not apply	40% coinsurance deductible applies	None
	Hospice services	No charge deductible does not apply	40% coinsurance deductible applies	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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 .)			
<ul style="list-style-type: none"> Dental Care (Adult/Child) Weight loss programs Glasses 	<ul style="list-style-type: none"> Long Term Care Private Duty Nursing 	<ul style="list-style-type: none"> 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.)			
<ul style="list-style-type: none"> Acupuncture (if prescribed for rehabilitation) Hearing aids Infertility treatment 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. Chiropractic Care 	<ul style="list-style-type: none"> Home birth 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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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, kwijigo 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.

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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	\$0
■ Specialist	\$25
■ Hospital (facility)	\$250
■ Other	\$100

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	\$11,840
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$860

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$0
■ Specialist	\$25
■ Hospital (facility)	\$250
■ Other	\$100

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	\$5,080
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$520

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist	\$25
■ Hospital (facility)	\$250
■ Other	\$100

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	\$2,300
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$500