



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:
<a href="#">What is the overall deductible?</a>	In network <b>\$0</b> Out-of-network <b>\$250</b> Individual <b>\$750</b> family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> , amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<a href="#">Are there services covered before you meet your deductible?</a>	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive</a> services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<a href="#">Are there other deductibles for specific services?</a>	No	You don't have to meet <a href="#">deductible</a> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<a href="#">What is the out-of-pocket limit for this plan?</a>	\$1,500 individual/\$3,000 family for in-and out-of-network <a href="#">providers</a> .	The <a href="#">out-of-pocket</a> limit is the most you could pay in a year for covered services. 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.
<a href="#">What is not included in the out-of-pocket limit?</a>	<a href="#">Copayments</a> for certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<a href="#">Will you pay less if you use a network provider?</a>	Yes. See <a href="http://www.phs.org">www.phs.org</a> or call 1-855-780-7737 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will 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 provider's charge and what your <a href="#">plan</a> 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.
<a href="#">Do you need a referral to see a specialist?</a>	No.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$10 <u>copayment</u> /visit <u>deductible</u> does not apply	40% <u>coinsurance</u> <u>deductible</u> applies	None
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit <u>deductible</u> does not apply	40% <u>coinsurance</u> <u>deductible</u> applies	None
	<u>Preventive care/screening/</u> immunization	No charge <u>deductible</u> does not apply	40% <u>coinsurance</u> <u>deductible</u> applies	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge <u>deductible</u> does not apply	40% <u>coinsurance</u> <u>deductible</u> applies	None
	Imaging (CT/PET scans, MRIs)	No charge <u>deductible</u> does not apply	40% <u>coinsurance</u> <u>deductible</u> applies	
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="https://client.formularynavigator.com/Search.aspx?siteCode=0322075909">https://client.formularynavigator.com/Search.aspx?siteCode=0322075909</a>	Generic drugs	\$10 <u>copay</u> /prescription (retail) & \$20 <u>copay</u> prescription (mail order) <u>deductible</u> does not apply	40% <u>coinsurance</u> <u>deductible</u> applies	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	\$20 <u>copay</u> /prescription (retail) & \$50 <u>copay</u> prescription (mail order) <u>deductible</u> does not apply	40% <u>coinsurance</u> <u>deductible</u> applies	
	Non-preferred brand drugs	\$35 <u>copay</u> /prescription (retail) & \$105 <u>copay</u> prescription (mail order) <u>deductible</u> does not apply	40% <u>coinsurance</u> <u>deductible</u> applies	
	<u>Specialty drugs</u>	Generic - \$10 Brand - \$20 Non-preferred - \$35 <u>copayment</u> /prescription (retail) Not Covered (mail order) <u>deductible</u> 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 <a href="#">copayment</a> <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a> <a href="#">deductible</a> applies	None
	Physician/surgeon fees	No charge <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a> <a href="#">deductible</a> applies	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	\$100 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	<a href="#">copayment</a> is waived if admitted into a Hospital, then Hospital <a href="#">copayment</a> applies.
	<a href="#">Emergency medical transportation</a>	No charge <a href="#">deductible</a> does not apply	No charge <a href="#">deductible</a> does not apply	None
	<a href="#">Urgent care</a>	\$50 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a> <a href="#">deductible</a> applies	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <a href="#">copayment</a> / admission <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a> <a href="#">deductible</a> applies	\$500 penalty may apply if Prior Authorization is not obtained for Out-of-Network services.
	Physician/surgeon fees	No charge <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a> <a href="#">deductible</a> applies	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <a href="#">copayment</a> /office visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a> <a href="#">deductible</a> applies	None
	Inpatient services	\$250 <a href="#">copayment</a> / admission <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a> <a href="#">deductible</a> applies	
If you are pregnant	Office visits	\$25 <a href="#">copayment</a> /initial visit only <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a> <a href="#">deductible</a> applies	None
	Childbirth/delivery professional services	No Charge <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a> <a href="#">deductible</a> applies	
	Childbirth/delivery facility services	\$250 <a href="#">copayment</a> / admission <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a> <a href="#">deductible</a> 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	<a href="#">Home health care</a>	No charge <u>deductible</u> does not apply	40% <u>coinsurance</u> <u>deductible</u> applies	None
	<a href="#">Rehabilitation services</a>	\$10 <u>copayment</u> /visit per day <u>deductible</u> does not apply	40% <u>coinsurance</u> <u>deductible</u> applies	None
	<a href="#">Habilitation services</a>	\$10 <u>copayment</u> /visit <u>deductible</u> does not apply	40% <u>coinsurance</u> <u>deductible</u> applies	None
	<a href="#">Skilled nursing care</a>	\$250 <u>copayment</u> /admission <u>deductible</u> does not apply	40% <u>coinsurance</u> <u>deductible</u> applies	Coverage is limited to 100 days for out-of-network providers.
	<a href="#">Durable medical equipment</a>	No charge <u>deductible</u> does not apply	40% <u>coinsurance</u> <u>deductible</u> applies	None
	<a href="#">Hospice services</a>	No charge <u>deductible</u> does not apply	40% <u>coinsurance</u> <u>deductible</u> 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.)

- Dental Care (Adult/Child)
- Weight loss programs
- Glasses
- Long Term Care
- 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
- 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](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 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, kwijjigo holne' 1-877-466-9236

Learn more about Presbyterian's Notice of Nondiscrimination, go to [www.phs.org/nondiscrimination.aspx](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a>	\$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*)

<b>Total Example Cost</b>	<b>\$11,840</b>
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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
<b>The total Peg would pay is</b>	<b>\$860</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a>	\$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*)

<b>Total Example Cost</b>	<b>\$5,080</b>
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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
<b>The total Joe would pay is</b>	<b>\$520</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a>	\$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*)

<b>Total Example Cost</b>	<b>\$2,300</b>
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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
<b>The total Mia would pay is</b>	<b>\$500</b>