



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) |

*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 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 | |

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| 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 |
|---|---|---|

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

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 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$800 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| 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 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$500 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| 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 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$500 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$500 |