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, 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?	**$0**	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. **$6,350** Individual **$12,700** family	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 ofnetwork 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 but only if you have a referral before you see the specialist.

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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	$15 copayment/visit	Not covered	There is zero cost sharing for any telehealth service.
	Specialist visit	$35 copayment/visit	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge for CT/PET scans & $50 copayment for MRI	Not covered	
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 copayment/ prescription (retail) $20 copayment/ prescription (mail order)	Not covered	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	$20 copayment/ prescription (retail) $50 copayment/ prescription (mail order)	Not covered	
	Non-preferred brand drugs	$35 copayment/ prescription (retail) $105 copayment/ prescription (mail order)	Not covered	
	Specialty drugs	15% coinsurance	Not covered	Coverage is limited up to a maximum of $250/injection and calendar year maximum of $1,500
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copayment/visit	Not covered	None
	Physician/surgeon fees	No charge	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).

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 immediate medical attention	Emergency room care	$100 copayment/visit	$100 copayment/visit	Copayment is waived if admitted into a Hospital, then Hospital copayment applies.
	Emergency medical transportation	$50 copayment/occurrence – Ground $100 copayment/ occurrence Air Ambulance	$50 copayment/ occurrence – Ground $100 copayment/ occurrence Air Ambulance	None
	Urgent care	$50 copayment/visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copayment/ admission	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copayment/visit	Not covered	None
	Inpatient services	$250 copayment/ admission	Not covered	
If you are pregnant	Office visits	$35 copayment/visit upto a maximum of $150/ pregnancy	Not covered	None
	Childbirth/delivery professional services	No Charge	Not covered	
	Childbirth/delivery facility services	$250 copayment/ admission	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	None
	Rehabilitation services	$25 copayment/session outpatient & $250 copayment inpatient	Not covered	None
	Habilitation services	$15 copayment/visit	Not covered	None
	Skilled nursing care	$250 copayment/	Not covered	Coverage is limited up to 60 days per

[*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)	
		admission		Calendar Year
	Durable medical equipment	50% coinsurance	Not covered	None
	Hospice services	$250 copayment/ admission	Not covered	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

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.)

- **Non-emergency care when traveling outside theU.S.**
- **Dental Care (Adult/Child)**
- **Weight loss programs**
  - **Glasses (Child)**
- **Long Term Care**
- **Most coverage provided outside the United**
- **Cosmetic surgery**
  - **Private Duty Nursing**
- **Routine eye care (Adult/Child)**
- **Routine Foot Care**
- **Bariatric surgery**
- **Infertility treatment**
- **Routine Vision Eye Exam (Child)**

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)**
- **Chiropractic Care**
- **Hearing aids (for children under 18 or 21 of age ifstill attending high school)**

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/No]

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, you may not be eligible for the premium tax credit.

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

Does this plan meet the Minimum Value Standards? [Yes/No/Not Applicable]

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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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	**$0**
Specialist *[cost sharing]*	**$35**
Hospital (facility) *[cost sharing]*	**$250**
Other *[cost sharing]*	**$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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$960**

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 *[cost sharing]*	**$35**
Hospital (facility) *[cost sharing]*	**$250**
Other *[cost sharing]*	**$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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	**$0**
Specialist *[cost sharing]*	**$35**
Hospital (facility) *[cost sharing]*	**$250**
Other *[cost sharing]*	**$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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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