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, go to member.accolade.com or call (833) 235-9280. 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/sbc-glossary/ or call member.accolade.com or call (833) 235-9280 to request a copy.

Questions	Answers	Why This Matters:
What is the overall deductible?	For participating providers: $1,000 person / $2,000 family For non-participating providers: $2,000 person / $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. For participating providers: Preventive care, diagnostic testing and imaging, emergency room care (all providers-emergency only), outpatient surgery, home health care, outpatient hospice services, initial prenatal visit, rehabilitation services, outpatient mental and substance abuse services, urgent care, primary care provider, routine eye exams, and specialist 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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	For participating providers: $3,000 person / $6,000 family For non-participating providers: $6,000 person / $12,000 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?	Premiums, preauthorization penalty amounts, 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 member.accolade.com or call (833) 235-9280 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.	You can see the specialist you choose without a referral.

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
		Participating Provider (you will pay the least)	Non-Participating 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	$30 copay/visit	50% coinsurance	Copay applies per visit regardless of what services are rendered. Includes telemedicine other than Teladoc. See your plan document for any costs associated with the Teladoc programs.
	Specialist visit	$50 copay/visit	50% coinsurance	
	Preventive care /screening /immunization	No Charge (preventive)/ 30% coinsurance (routine)	30% coinsurance (gynecological exam & pap smear)/ 50% coinsurance (all other preventive care)	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. There is no charge for routine immunizations through age 19.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No Charge	50% coinsurance	Preauthorization required for MRI, MRA and PET scans. If you don't get preauthorization, benefits could be reduced by $400 of the total cost of the service from a non-participating provider.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$5 copay (30-day retail)/$12.50 copay (MCN or mail order)	50% coinsurance (30-day retail)	Major medical deductible applies to non-participating providers. Covers up to a 30-day supply (retail prescription); 90-day supply (Maintenance Choice Network (MCN) or mail order prescription); 30-day supply (specialty drugs). The copay applies per prescription. There is no charge or deductible for preventive drugs. There is no deductible for preventive maintenance drugs; applicable copay applies. Specialty drugs must be obtained from the specialty pharmacy network. Certain specialty drugs are eligible for copay assistance programs
	Preferred brand drugs	$40 copay (30-day retail)/$100 copay (MCN or mail order)	50% coinsurance (30-day retail)	
	Non-preferred brand drugs	$75 copay (30-day retail)/$187.50 copay (MCN or mail order)	50% coinsurance (30-day retail)	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (you will pay the least)	Non-Participating Provider (you will pay the most)	
	Specialty drugs	$200 copay * (30-day retail)	Not Covered	through CVS True Accumulation Program. Step therapy provision applies. *Certain specialty drugs may be eligible for a $0 copay if you are enrolled under the PrudentRx Solutions Program. If drugs are eligible under the Prudent Rx Solution Program and you do not enroll you will be subject to a 30% copay.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Preauthorization required for certain surgeries. If you don't get preauthorization, benefits could be reduced by $400 of the total cost of the service from a non-participating provider. See your plan document for a detailed listing.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$250 copay/visit (emergency services)/Not Covered (non-emergency services)	$250 copay/visit (emergency services)/Not Covered (non-emergency services)	Non-participating providers paid at the participating provider level of benefits for emergency services. Copay is waived if admitted to the hospital.
	Emergency medical transportation	30% coinsurance (emergency services)/ Not Covered (non-emergency services)	30% coinsurance (emergency services)/ Not Covered (non-emergency services)	Non-participating providers paid at the participating provider level of benefits for emergency services. Preauthorization required for air ambulance for non-emergent transportation. If you don't get preauthorization, benefits could be reduced by $400 of the total cost of the service from a non-participating provider.
	Urgent care	$50 copay/visit	50% coinsurance	Copay applies per visit regardless of what services are rendered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (you will pay the least)	Non-Participating Provider (you will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Preauthorization required. If you don't get preauthorization, benefits could be reduced by $400 of the total cost of the service from a non-participating provider.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Preauthorization required. If you don't get preauthorization, benefits could be reduced by $400 of the total cost of the service from a non-participating provider.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	50% coinsurance	Includes telemedicine other than Teladoc. Includes Teladoc behavioral health consultations.
	Inpatient services	30% coinsurance	50% coinsurance	Preauthorization required. If you don't get preauthorization, benefits could be reduced by $400 of the total cost of the service from a non-participating provider.
If you are pregnant	Office visits	30% coinsurance ($30 copay on initial visit)	50% coinsurance	Preauthorization required for inpatient hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (c-section). If you don't get preauthorization, benefits could be reduced by $400 of the total cost of the service from a non-participating provider. Cost sharing does not apply to preventive services from a participating provider. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby does not count toward the mother's expense; therefore the family deductible amount may apply.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Limited to 200 visits per year and 3 visits per day. Preauthorization required. If you don't get preauthorization, benefits could be reduced by $400 of the total cost of the service from a non-participating provider.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (you will pay the least)	Non-Participating Provider (you will pay the most)	
	Rehabilitation services	$50 copay/visit	50% coinsurance	Physical therapy limited to 60 visits per year. Occupational and speech/hearing therapy limited to a maximum of 30 visits per each type of therapy per year.
	Habilitation services	$50 copay/visit	50% coinsurance	None
	Skilled nursing care	30% coinsurance	50% coinsurance	Limited to 60 days per year. Preauthorization required. If you don't get preauthorization, benefits could be reduced by $400 of the total cost of the service from a non-participating provider.
	Durable medical equipment	30% coinsurance	50% coinsurance	Preauthorization required for electric/ motorized scooters or wheelchairs and pneumatic compression devices and for any item in excess of $1,000. If you don't get preauthorization, benefits could be reduced by $400 of the total cost of the service from a non-participating provider.
	Hospice services	30% coinsurance	50% coinsurance	Bereavement counseling is covered if received within 6 months of death.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to 1 exam per 24 months.
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	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.)		
• Acupuncture - (except in lieu of anesthesia) • Cosmetic surgery • Dental care (Adult & Child) • Long-term care	• Non-emergency care when traveling outside the U.S. • Routine foot care - (except for metabolic or peripheral vascular disease) • Weight loss programs	• Emergency room services for non-emergency services • Glasses (Adult & Child) • Private-duty nursing (inpatient) • Ambulance transportation for non-emergency services
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery - (for morbid obesity only – 1 surgical procedure per lifetime) • Chiropractic care	• Hearing aids - ($2,500 per 24 months; 1 aid per ear) • Fertility treatment (2 cycle maximum through Kindbody only)	• Private-duty nursing - (outpatient – 60 8-hour shifts per year) • Routine eye care - (Adult & Child – 1 exam per 24 months)

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:

- For more information on your rights to continue coverage, contact Accolade at (833) 235-9280.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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

Does this plan meet 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.

To see examples of how this plan might cover costs for a sample medical situation, see the next section

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	**$1,000**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	$1,000
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

The plan's overall deductible	**$1,000**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Primary care provider office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Diabetic supplies *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$1,100
Coinsurance	$0
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	**$1,000**
Specialist copayment	**$50**
Hospital (facility) copayment	**$250**
Other coinsurance	**30%**

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	$900
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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