



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 (866) 406-1338. 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 www.healthcare.gov/sbc-glossary or call Accolade at (866) 406-1338 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For participating <u>providers</u> : \$500 person / \$1,200 family For non-participating <u>providers</u> : \$800 person / \$2,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. For participating <u>providers</u> : <u>Preventive care</u> , <u>urgent care</u> office visit charges, office visit charges, inpatient mental health & substance abuse services, <u>rehabilitation services</u> , <u>habilitation services</u> and prenatal and postnatal services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For participating <u>providers</u> : \$3,000 person / \$6,000 family For non-participating <u>providers</u> : \$5,000 person / \$10,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See member.accolade.com or call (800) 343-3140 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
Is a Health Reimbursement Arrangement (HRA) available under this plan option?	Yes, if you are in a job grade 15-19 you are eligible for: \$500 individual / \$1,200 family. For details on the HRA call HealthEquity at (866)-346-5800.	An HRA is an account that is set up and contributed to by your employer. You may not make any contributions to the HRA. The HRA may only be used to pay a portion of your <u>out-of-pocket</u> expenses incurred under the <u>plan</u> .

 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	\$20 <u>copay</u> /visit (office visit)/ 10% <u>coinsurance</u> (all other services)	30% <u>coinsurance</u>	<u>Copay</u> applies to the physician office visit only. Includes telemedicine. You pay a \$10 <u>copay</u> (<u>deductible</u> does not apply) if you have visits with AccoladeCare <u>providers</u> .
	<u>Specialist</u> visit	\$35 <u>copay</u> /visit (office visit)/ 10% <u>coinsurance</u> (all other services)	30% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No Charge	30% <u>coinsurance</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 18 presumptive drug tests and 18 definitive drug tests per year.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for MRI, MRA and PET scans. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$250 maximum per occurrence.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com	Generic drugs	\$10 <u>copay</u> (30-day retail)/ \$20 <u>copay</u> (90-day retail, CVS & mail order)	Not Covered	<u>Deductible</u> does not apply. Covers up to a 90-day supply (retail prescription); 90-day supply (mail order prescription); 30-day supply (<u>specialty drugs</u>). The <u>copay</u> applies per prescription. There is no charge for preventive drugs. Member must pay the difference between the cost of a preferred generic and the brand if the member elects to fill the brand. <u>Specialty drugs</u> must be obtained directly from the specialty pharmacy. Certain <u>specialty drugs</u> are eligible for <u>copay</u> assistance programs through CVS True Accumulation Program. After 2 fills, maintenance drugs must be purchased as a 90-day supply and must
	Preferred brand drugs	\$25 <u>copay</u> (30-day retail)/ \$50 <u>copay</u> (90-day retail, CVS & mail order)	Not Covered	
	Non-preferred brand drugs	\$40 <u>copay</u> (30-day retail)/ \$80 <u>copay</u> (90-day retail, CVS & mail order)	Not Covered	
	<u>Specialty drugs</u>	\$10 <u>copay</u> (generic) / \$25 <u>copay</u> (preferred) / \$40 <u>copay</u> (non-preferred)	Not Covered	

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)	
				be purchased at either a CVS retail pharmacy or through the mail order program, unless you opt out. Step therapy provision applies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 <u>copay</u> /occurrence, then 10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for certain surgeries. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$250 maximum per occurrence. See your <u>plan</u> document for a detailed listing.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copay</u> /visit, then 10% <u>coinsurance</u> (<u>emergency services</u> & non- <u>emergency services</u>)	\$250 <u>copay</u> /visit, then 10% <u>coinsurance</u> (<u>emergency services</u>) / \$250 <u>copay</u> /visit, then 30% <u>coinsurance</u> (non- <u>emergency services</u>)	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits for <u>emergency services</u> . <u>Copay</u> is waived if admitted to the hospital.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits. <u>Preauthorization</u> required for air ambulance for non-emergent transportation. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$250 maximum per occurrence.
	<u>Urgent care</u>	\$35 <u>copay</u> /visit (office visit)/ 10% <u>coinsurance</u> (all other services)	30% <u>coinsurance</u>	<u>Copay</u> applies to the physician office visit only.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <u>copay</u> /admission, then 10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$250 maximum per occurrence.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need mental health, behavioral	Outpatient services	\$20 <u>copay</u> /visit (office visit)/ 10% <u>coinsurance</u> (all other outpatient)	\$20 <u>copay</u> /visit (office visit)/ 30% <u>coinsurance</u> (all other outpatient)	Includes telemedicine. You pay a \$10 <u>copay</u> (<u>deductible</u> does not apply) if you have visits with AccoladeCare <u>providers</u> .

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)	
health, or substance abuse services	Inpatient services	No charge, <u>deductible</u> does not apply (facility charges & professional fees)	30% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$250 maximum per occurrence.
If you are pregnant	Office visits	No Charge (\$20 <u>copay</u> on initial visit)	30% <u>coinsurance</u>	<u>Preauthorization</u> required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$250 maximum per occurrence. <u>Cost sharing</u> does not apply to <u>preventive services</u> from a participating provider. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <u>Deductible</u> does not apply to inpatient facility charges. Baby counts towards the mother's expense.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$250 <u>copay</u> /admission, then 10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 120 visits per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$250 maximum per occurrence.
	<u>Rehabilitation services</u>	\$35 <u>copay</u> /visit	30% <u>coinsurance</u>	Physical & occupational therapy limited to a combined maximum of 24 visits per year; speech therapy limited to 60 visits per year. Additional visits for all therapies may be available when <u>medically necessary</u> .
	<u>Habilitation services</u>	\$35 <u>copay</u> /visit	30% <u>coinsurance</u>	-----none-----
	<u>Skilled nursing care</u>	\$250 <u>copay</u> /admission, then 10% <u>coinsurance</u>	\$250 <u>copay</u> /admission, then 30% <u>coinsurance</u>	Limited to 120 days per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$250 maximum per occurrence.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for electric/motorized scooters or wheelchairs,

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)	
				pneumatic compression devices and for any item in excess of \$1,000. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% up to \$250 maximum per occurrence. Limited to a single purchase per type of <u>durable medical equipment</u> every 3 years (including repairs/replacements).
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Bereavement counseling is covered if received within 6 months of death.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult & Child) • Glasses (Adult & Child) 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing (inpatient) 	<ul style="list-style-type: none"> • Routine eye care (Adult & Child) • Routine foot care (except for metabolic or peripheral vascular disease) • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> • Acupuncture (24 visits per year) • Bariatric surgery (for morbid obesity only) 	<ul style="list-style-type: none"> • Chiropractic care (24 visits per year) • Hearing aids (1 per hearing impaired ear every 24 months) 	<ul style="list-style-type: none"> • Infertility (through Progyny only) • Private-duty nursing (outpatient)

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: the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/healthreform or Accolade at (866) 406-1338. 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 (866) 444-3272 or www.dol.gov/ebsa/healthreform or Accolade at (866) 406-1338.

Additionally, a consumer assistance program can help you file your [appeal](#). Contact the California Department of Insurance at (800) 927-4357.

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 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 1-800-378-1179.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-378-1179.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-800-378-1179.

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 <u>plan's overall deductible</u>	\$500
■ <u>Primary care physician coinsurance</u>	0%
■ Hospital (facility) <u>copayment</u>	\$250
■ Other <u>coinsurance</u>	10%

This **EXAMPLE** event includes services like:

Primary care physician 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$260
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,020

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's overall deductible</u>	\$500
■ <u>Specialist copayment</u>	\$35
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	10%

This **EXAMPLE** event includes services like:

Specialist office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$700
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,260

Mia's Simple Fracture

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

■ The <u>plan's overall deductible</u>	\$500
■ <u>Specialist copayment</u>	\$35
■ Hospital (facility) <u>copayment</u>	\$250
■ Other <u>coinsurance</u>	10%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$500
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100