**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) 909-2353. 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 (833) 909-2353 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For participating providers:<br>$1,500 person / $3,000 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 - independent facility, emergency room care, rehabilitation services, habilitation services, routine eye exam, urgent care and office visits 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 www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes. $100 individual / $300 family for prescription drug coverage. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | For participating providers:<br>$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, 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) 909-2353 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 | No Charge (Health Center providers)/$60 copay/visit (all other providers) | Not Covered | Copay applies per visit regardless of what services are rendered. There is no charge and the deductible does not apply if you receive general medical and dermatology consultation services through Teladoc. |
| | Specialist visit | $75 copay/visit | Not Covered | |
| | Preventive care/screening/ immunization | No Charge | Not Covered | 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 (independent facility)/20% coinsurance (all other outpatient locations | Not Covered | ----------none---------- |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | Not Covered | Preauthorization recommended for MRI, MRA and PET scans. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.optumrx.com | Generic drugs | 20% copay ($10 min/$30 max - retail)/20% copay ($25 min/$50 max - mail order) | Not Covered | Prescription drug deductible applies. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription); 30-day supply (specialty drugs). The copay applies per prescription. There is no charge or deductible for preventive drugs. Dispense as Written (DAW) provision applies. Specialty drugs must be obtained directly from the specialty pharmacy. Step Therapy provision applies. |
| | Preferred brand drugs | 20% copay ($30 min/$50 max - retail)/20% copay ($75 min/$125 max - mail order) | Not Covered | |
| | Non-preferred brand drugs | 20% copay ($50 min/$75 max - retail)/20% copay ($125 min/$175 max - mail order) | Not Covered | |
| | Specialty drugs | 20% copay up to $200 max | 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) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | Not Covered | Preauthorization recommended for certain surgeries. There is no charge and the deductible does not apply for certain surgeries through SurgeryPlus™. See your plan document for a detailed listing. |
| | Physician/surgeon fees | 20% coinsurance | Not Covered | |
| **If you need immediate medical attention** | Emergency room care | $300 copay/visit (emergency services)/$300 copay/visit then 50% coinsurance (non-emergency services) | $300 copay/visit (emergency services)/$300 copay/visit then 50% coinsurance (non-emergency services) | Non-participating providers paid at the participating provider level of benefits. Copay is waived if admitted to the hospital. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Non-participating providers paid at the participating provider level of benefits. Preauthorization recommended for air ambulance for non-emergent transportation. |
| | Urgent care | $75 copay/visit | Not Covered | Copay applies per visit regardless of what services are rendered. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | Not Covered | Preauthorization recommended. |
| | Physician/surgeon fees | 20% coinsurance | Not Covered | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No Charge (office visit) /20% coinsurance (all other outpatient) | Not Covered | Includes Teladoc behavioral health consultations. |
| | Inpatient services | 20% coinsurance | Not Covered | Preauthorization recommended. |
| **If you are pregnant** | Office visits | 20% coinsurance ($60 copay on initial visit) | Not Covered | Preauthorization recommended for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). 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 counts towards the mother's expense. |
| | Childbirth/delivery professional services | 20% coinsurance | Not Covered | |
| | Childbirth/delivery facility services | 20% coinsurance | 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) | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | Not Covered | Limited to 60 visits per year. Preauthorization recommended. |
| | Rehabilitation services | $15 copay/visit (Airrosti providers)/$60 copay/visit (all other providers) | Not Covered | Physical, speech & occupational therapy limited to a combined maximum of 60 visits per year. Visit limit does not apply to Airrositi providers. |
| | Habilitation services | $60 copay/visit | Not Covered | Limits are combined with rehabilitation services limits listed above. |
| | Skilled nursing care | 20% coinsurance | Not Covered | Limited to 60 days per year. Preauthorization recommended. |
| | Durable medical equipment | 20% coinsurance | Not Covered | Preauthorization recommended for electric/motorized scooters or wheelchairs and pneumatic compression devices and for any item in excess of $1,000. |
| | Hospice services | 20% coinsurance | Not Covered | Bereavement counseling is covered if received within 6 months of death. Inpatient/outpatient services are limited to 360 days/visits per lifetime. |
| **If your child needs dental or eye care** | Children's eye exam | No Charge | Not Covered | Limited to 1 exam per 24 month period. |
| | 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.)**

- **Bariatric surgery**
- **Cosmetic surgery**
- **Dental care (Adult & Child)**
- **Glasses (Adult & Child)**
- **Hearing aids (age 19 and over)**
- **Infertility treatment (except diagnosis)**
- **Long-term care**
- **Non-emergency care when traveling outside the U.S.**
- **Private-duty nursing (except for home health care & hospice)**
- **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 plan document.)**

- **Acupuncture (in lieu of anesthesia only)**
- **Chiropractic care (24 visits per year)**
- **Hearing aids (up to age 19 - 1 aid per ear up to $2,500 per year)**
- **Routine eye care (Adult & Child - 1 exam per 24-month period)**

**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 Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at (877) 267-2323 x 61565 or www.cciio.cms.gov, or Accolade at (833) 909-2353. 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 Accolade at (833) 909-2353.

Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Consumer Health Assistance Program, Texas Department of Insurance at (800) 252-3439.

**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, kwiijigo 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 plan's overall deductible** | **$1,500** |
| **Primary care physician coinsurance** | **20%** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **20%** |

**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** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $1,500 |
| Copayments | $0 |
| Coinsurance | $2,200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | $3,760 |

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

| | |
|---|---|
| **The plan's overall deductible** | **$1,500** |
| **Specialist copayment** | **$75** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **20%** |

**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** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $1,000 |
| Copayments | $600 |
| Coinsurance | $700 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | $2,320 |

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

| | |
|---|---|
| **The plan's overall deductible** | **$1,500** |
| **Specialist copayment** | **$75** |
| **Hospital (facility) copayment** | **$300** |
| **Other coinsurance** | **20%** |

**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* | $1,400 |
| Copayments | $800 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $2,200 |

*Note: This plan has other **deductibles** for specific services included in this coverage example. See "Are there other deductibles for specific services."

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