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, member.accolade.com. 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 1-844-467-3579 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $6,550 / Individual or $13,100 / Family. Non-Network Providers:$13,100 / Individual or $26,200 / 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?	Network providers Yes. Preventive care services. Non-Network Providers: No	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?	Network providers $6,550 Individual / $13,100 Family. Non-Network Providers: $13,500 Individual / $27,000 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, penalties for failure to obtain preauthorization for services, Non-network transplant, non-network prescription drugs, non-network specialty drugs.	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 provider.bcbs.com detailed instructions can be found here or call 1-844-467-3579 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 the specialist you choose without a referral.

* For more information about limitations and exceptions, see the plan or policy document at member.accolade.com.

⚠ 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	0% after deductible	20% after deductible	None
	Specialist visit	0% after deductible	20% after deductible	None
	Preventive care/screening/ immunization	No charge	20% after deductible	You may have to pay for services that aren't preventive care. Ask your provider if the services needed are preventive care. Then check what your plan will pay for. Breast Feeding Counseling for Non-PAR is No charge. Male Sterilization is SAAOD for PAR and Non PAR. Male Contraceptives and Hearing Exam & Testing are Not covered for PAR and Non-PAR.
If you have a test	Diagnostic test (x-ray, blood work)	0% after deductible	20% after deductible	None
	Imaging (CT/PET scans, MRIs)	0% after deductible	20% after deductible	Preauthorization is required - If not obtained, penalty will be 50%. *See Nimble Health program.

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 drugs to treat your illness or condition More information about **prescription drug coverage** at humanaassociaterx-rxportal.sxc.com	**Tier 1 - Lower-cost** generics and some brand-name drugs	0% coinsurance, after deductible (Retail) / (Mail Order)	Contracted rate after the applicable coinsurance	30-day supply (Retail) 90-day supply (Mail Order) • Preauthorization and / or step therapy is required for some medications. • Preventive medicines on the OptumRx Preventive Drug List have the copays listed below. Medications can be filled at a 30-day supply at any in-network pharmacy and 90-day supply at Optum Home Delivery, CenterWell Pharmacy retail locations or CVS. If the drug is a maintenance medication, the Maintenance Rx requirement apply. Tier 1: $10 copay(30-days)/$20 copay(90-days) Tier 2: $40 copay(30-days)/$80 copay(90-days) Tier 3: $70 copay(30-days)/$140 copay(90-days) • Formulary Tier 2 insulins can be obtained at no cost for a 30-day supply from any in-network pharmacy. • Formulary Tier 3 insulins can be obtained at $35 for a 30-day supply from any in-network pharmacy. • Formulary Tier E (excluded) insulins require an approved override exception. If approved, the Tier 3 cost share applies. • Maintenance medicines filled via 90-day prescriptions must be filled at Optum Home Delivery, CenterWell Pharmacy retail locations, or using CVS 90-Saver Program after two fills at any in-network retail pharmacy. If continued to fill at an in-network retail pharmacy (other than using CVS 90-Saver), the medication will not be covered. To view the formulary (drug list), visit humanaassociaterx-rxportal.sxc.com
	Tier 2 - Mid-range cost preferred brand-name drugs	0% coinsurance, after deductible (Retail) / (Mail Order)		
	Tier 3 - Higher-cost brand-name and some generics	0% coinsurance, after deductible (Retail) / (Mail Order)		
	Specialty drugs (including self-administered specialty)	0% coinsurance, after deductible (Retail)	Not Covered	Members are required to use Optum Specialty Pharmacy to fill specialty medications. If the medication is filled at any other pharmacy, it is not covered.

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)	
	Office-Administered Specialty drugs	Injectable: 0% coinsurance after deductible	Injectable: 0% after deductible	30-day supply Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug. Injectable medicines received in office, clinic or outpatient setting are typically covered under the medical benefit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% after deductible	20% after deductible	Preauthorization is required - If not obtained, penalty will be 50%. ***See COE Requirement
	Physician/surgeon fees	0% after deductible	20% after deductible	***See COE Requirement
If you need immediate medical attention	Emergency room care True Emergency Non-Emergency	0% after deductible 0% after deductible	0% after In-network deductible 20% after Out-of-network deductible	None
	Emergency medical transportation	0% after deductible	0% after In-network deductible	None
	Urgent care	0% after deductible	20% after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% after deductible	20% after deductible	Preauthorization is required - If not obtained, penalty will be 50%. ***See COE Requirement

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)	
	Physician/surgeon fees	0% after deductible	20% after deductible	***See COE Requirement
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Therapy: 0% after deductible Other outpatient non-surgical services:0% after deductible	20% after deductible	Preauthorization may be required - if not obtained, penalty will be 50%.
	Inpatient services	0% after deductible	20% after deductible	Preauthorization is required - If not obtained, penalty will be 50%.
If you are pregnant	Office visits	0% after deductible	20% after deductible	Depending on the type of services, coinsurance or deductible may apply. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	0% after deductible	20% after deductible	Depending on the type of services, coinsurance or deductible may apply.
	Childbirth/delivery facility services	0% after deductible	20% after deductible	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
If you need help recovering or have other special health needs	Home health care	0% after deductible	20% after deductible	120 visits per year. Preauthorization may be required - if not obtained, penalty will be 50%.
	Rehabilitation services	0% after deductible	20% after deductible	60 combined visits per year for Occupational, Physical, and Speech Therapies Preauthorization may be required - if not obtained, penalty will be 50%.
	Habilitation services	0% after deductible	20% after deductible	60 combined visits per year for Occupational, Physical, and Speech Therapies Preauthorization may be required - if not obtained, penalty will be 50%.

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)	
	Skilled nursing care	0% after deductible	20% after deductible	120 visits per year Preauthorization may be required - if not obtained, penalty will be 50%.
	Durable medical equipment	0% after deductible	20% after deductible	Preauthorization is required - If not obtained, penalty will be 50%.
	Hospice services	0% after deductible	20% after deductible	None
If your child needs dental or eye care	Children's eye exam	No Charge	20% coinsurance	Limited 1 exam/benefit year.
	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.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Child)
- Long-term care
- Routine foot care
- Prescription Drugs (Covered by OptumRx)
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture, 12 visits/benefit year
- Chiropractic care, 30 visits/benefit year
- Hearing Aids
- Infertility treatment, diagnosis/testing/treatment of underlying condition
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing, if part of pre-authorized home health care
- Routine Eye Care (Adult)
- Routine Eye Care (Child)

*** Imaging procedures scheduled through Nimble Health are covered at 100% after the member has met the IRS minimum deductible ($1,600 person/$3,200 family) for the Coverage Period.**

*****Centerwell Smartcare Centers are considered In Network for this Plan. Surgeries and procedures performed at the Smartcare Centers are covered at 100% after the member has met the IRS minimum deductible ($1,600 person/$3,200 family) for the Coverage Period.**

*****Centerwell Smartcare Centers Requirement: Surgeries or Procedures related to spine, joint replacement, cardiac and cancer will not be covered unless performed at one of the Centerwell Smartcare Centers. Pre-authorization for spine, joint replacement, cardiac and cancer surgeries and procedures is required seven (7) days in advance of the procedure. Penalty for not obtaining Pre-authorization within the required timeframe is 50% per occurrence.**

* For more information about limitations and exceptions, see the plan or policy document at member.accolade.com.

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 group health coverage subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or 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 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:

- Your plan at 844-467-3579
- Department of Labor Employee Benefits Security Administration: 866-444-EBSA (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 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 1-844-467-3579.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-467-3579.

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-467-3579.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-467-3579.

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** **$6,550**
- **Specialist copayment** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	$6,550
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$6,620**

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

- **The plan's overall deductible** **$6,550**
- **Specialist copayment** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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*	$1,100
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$5,400**

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

- **The plan's overall deductible** **$6,550**
- **Specialist copayment** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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*	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$2,810**

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