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 1-800-882-5158 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1-3 In-Network: **$2,500 /** individual or **$5,000 /** family per calendar year. Shares with prescription drugs.	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is 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?	Tier 1-3 In-Network: **$5,000** / individual or **$10,000** / family per calendar year. (no family member will meet more than $9,200)	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain preauthorization for 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 member.accolade.com or call 1-866-336-0735 for a list of network providers.	This plan uses a provider network. You pay the least if you use a provider in Tier 1. You pay more if you use a provider in Tier 2 or Tier 3. 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				
		Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	$50 copay/visit	$90 copay/visit	Not covered	Virtual visit with AccoladeCare, Aligned Marketplace $0 copay/visit. All other Tier 1 providers: $10 copay/visit Tier 2 and Tier 3 virtual providers follow PCP copay.
	Specialist visit	$60 copay/visit	$140 copay/visit	$300 copay/visit	Not covered	None.
	Preventive care/screening/ immunization	No charge deductible does not apply	No charge deductible does not apply	No charge deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Routine diagnostic labs: $50 copay/test	Routine diagnostic labs: $75 copay/test	Routine diagnostic labs: $150 copay/test	Not covered	Fee listed include facility and physician charges; preauthorization may be required for some services. Diagnostic Radiology through OneImaging $25 copay/test.
		Diagnostic Radiology: $75 copay/test	Diagnostic Radiology: $200 copay/test	Diagnostic Radiology: $500 copay/test	Not covered	
		Diagnostic Labs: $175 copay/test	Diagnostic Labs: $200 copay/test	Diagnostic Labs: $400 copay/test	Not covered	
	Imaging (CT/PET scans, MRIs)	$200 copay/test	$500 copay/test	$800 copay/test	Not covered	Preauthorization is required. Advanced Imaging with OneImaging: $100 copay/test CT Scans and MRIs are required through OneImaging. See Plan Document* for details.

Common Medical Event	Services You May Need	What You Will Pay				
		Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at affirmedrx.com/7-eleven. If you need more information for Specialty Drugs, please visit MyVivio.com If you need more information for fertility drugs, please visit app.get-carrot.com.	Tier 1 (Generic) drugs	Retail: $10 copay Mail Order: $25 copay			Not covered	Prior authorization required for specific drugs; benefits listed are for a 30-day supply at retail, and 90-day supply at in-network mail order* **Including, but not limited to, maintenance medications, must be filled through Amazon Pharmacy. Please call Amazon Pharmacy at 855-206-3605 or visit www.amazon.com/homedelivery-meds.* Payment of the difference between the cost of a brand-name drug and a generic may be required if a generic drug is available. Access to GLP-1 medications for weight loss requires enrollment in the Verily program. Certain infusions are required to go through Lantern.
	Tier 2 (Preferred brand) drugs	Retail: 30% coinsurance ($30 min, $75 max) Mail Order: 30% coinsurance ($75 min, $188 max)				
	Tier 3 (Non-preferred brand) drugs	Retail: 30% coinsurance ($60 min, $150 max) Mail Order: 30% coinsurance ($150 min, $375 max)				
	Tier 4 (Specialty) drugs	$0 copay			Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$1,500 copay	$2,000 copay	$3,500 copay	Not covered	Preauthorization is required. See your Plan Document* for details. Facility fee listed includes facility and physician charges associated with outpatient facility and surgical services. Spine, Joint, and Bariatric surgeries are required to go through Lantern.
	Physician/surgeon fees	$0 copay	$0 copay	$0 copay	Not covered	None.

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

Common Medical Event	Services You May Need	What You Will Pay				
		Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	$750 copay/visit	Tier 1 Preferred provider benefit applies	Tier 1 Preferred provider benefit applies	Tier 1 Preferred provider benefit applies	Copay waived if admitted. Facility fee listed includes facility and physician charges associated with medical emergency services.
	Emergency medical transportation	$750 copay/visit	Tier 1 Preferred provider benefit applies	Tier 1 Preferred provider benefit applies	Tier 1 Preferred provider benefit applies	Preauthorization required for non-emergency air ambulance.
	Urgent care	$100 copay/visit	$100 copay/visit	$100 copay/visit	Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$2,000 copay	$3,000 copay	$4,000 copay	Not covered	Preauthorization is required. See your Plan Document* for details. Facility fee listed includes facility and physician charges associated with inpatient services. Spine, Joint, and Bariatric surgeries are required to go through Lantern.
	Physician/surgeon fees	$0 copay	$0 copay	$0 copay	Not covered	None.

If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit	$50 copay/visit	$90 copay/visit	Not covered	Preauthorization may be required for some services; see your Plan Document* for details. Virtual visit with AccoladeCare, Aligned Marketplace, Pelago $0 copay/visit. All other Tier 1 providers: $10 copay/visit Tier 2 and Tier 3 virtual providers follow PCP copay
	Inpatient services	$2,000 copay	$3,000 copay	$4,000 copay	Not covered	Preauthorization is required. Facility fee listed includes facility and physician charges associated with inpatient services.
If you are pregnant	Office visits	$20 copay/visit	$50 copay/visit	$90 copay/visit	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	$0 copay	$0 copay	$0 copay	Not covered	
	Childbirth/delivery facility services	$2,000 copay	$3,000 copay	$4,000 copay	Not covered	

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

If you need help recovering or have other special health needs	Home health care	$150 copay	$200 copay	$300 copay	Not covered	Maximum: 180 visits / calendar year. Preauthorization is required for OT,PT,ST and skilled nursing services performed in the home.
	Rehabilitation services	$50 copay	$100 copay	$300 copay	Not covered	Maximum: 60 visits / calendar year. Speech therapy maximum 30 visits / calendar year.
	Habilitation services					
If you need help recovering or have other special health needs	Skilled nursing care	$2,000 copay	$3,000 copay	$4,000 copay	Not covered	Maximum: 180 visits / calendar year. Preauthorization is required.
	Durable medical equipment	$250 copay	$400 copay	$600 copay	Not covered	Foot orthotics/orthopedic shoes are covered. Preauthorization is required.
	Hospice services	$400 copay	$600 copay	$900 copay	Not covered	None.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered.	None.
	Children's glasses	Not covered	Not covered	Not covered	Not covered.	None.
	Children's dental check-up	Not covered	Not covered	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.)

- Cosmetic surgery
- Dental care (Adult and Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)

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

- Acupuncture (max. 25 visits / calendar year)
- Bariatric surgery(max. 1 surgical procedure per lifetime)
- Chiropractic care (max. 25 visits / calendar year)
- Hearing aids (1 per ear every 5 years)
- Infertility treatment (Lifetime max. $20,000)
- Routine foot care (covered for certain conditions)
- Weight loss programs

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-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 1-866-336-0735.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-336-0735.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-336-0735.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-336-0735.

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 at member.accolade.com.

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	$2,500
Specialist copayment	$60
Hospital (facility) copayment	$2,000
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	$2,500
Copayments	$2,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

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

The plan's overall deductible	$2,500
Specialist copayment	$60
Hospital (facility) copayment	$2,000
Other coinsurance	30%

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	$2,500
Copayments	$100
Coinsurance	$600
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,220**

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

The plan's overall deductible	$2,500
Specialist copayment	$60
Hospital (facility) copayment	$2,000
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	$2,500
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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