# Medical Benefit Booklet

The Bank of New York Mellon Corporation

Copay Plan
Lower Deductible HSA Plan
Higher Deductible HSA Plan

Effective 01/01/2023

Administered by Anthem

**Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de Servicio al Cliente que aparece en el reverso de su Tarjeta de Identificación.**

**If You need assistance in Spanish to understand this document, You may request it for free by calling Member Services at the number on Your Identification Card.**

This Benefit Booklet provides You with a description of Your benefits while You are enrolled under the medical Plan (Copay Plan, Lower Deductible HSA Plan or Higher Deductible HSA Plan, as applicable) sponsored by The Bank of New York Mellon Corporation. You should read this Benefit Booklet carefully to familiarize yourself with the Plan's main provisions and keep it handy for reference. A thorough understanding of Your coverage will enable You to use Your benefits wisely. If You have any questions about the benefits as presented in this Benefit Booklet, please contact Accolade Member Services at the number on the back of Your Member Identification Card during normal business hours (8:00 a.m. to 11:00 p.m. eastern time).

The Plan provides the benefits described in this Benefit Booklet only for eligible Members. The health care services are subject to the **Limitations and Exclusions**, Copayments, Deductible, and Coinsurance requirements specified in this Benefit Booklet. Any group medical plan or certificate which You received previously will be replaced by this Benefit Booklet.

**NOTE: Words and phrases within this document that are denoted with initial capitalization have the meaning ascribed to them within the document itself, or within the Definitions section.**

**Your Employer has agreed to be subject to the terms and conditions of Anthem Blue Cross and Blue Shield's Provider agreements which may include Precertification and utilization management requirements, timely filing limits, and other requirements to administer the benefits under the Plan.**

Anthem Blue Cross and Blue Shield, or "Anthem" has been designated by Your Employer to provide administrative services for the medical benefits under the Employer's Group Health Plan, such as claims processing, Precertification, and other services, and to arrange for a network of health care Providers whose services are covered by the Plan.

Important: This is not an insured benefit Plan. The benefits described in this Benefit Booklet or any rider or amendments attached hereto are funded by the Employer who is responsible for their payment. **Anthem** provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Anthem Blue Cross and Blue Shield is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, permitting Anthem to use the Blue Cross and Blue Shield Service Marks. Although Anthem is the Claims Administrator, You will have access to Providers participating in the Blue Cross and Blue Shield Association BlueCard® PPO Network across the country. Anthem has entered into a contract with the Employer on its own behalf and not as the agent of the Association.

**Verification of Benefits**
Verification of benefits is available for Members or authorized healthcare Providers on behalf of Members. You may call Accolade Member Services with a benefits inquiry or verification of benefits during normal business hours (8:00 a.m. to 11:00 p.m. eastern time). Please remember that a benefits inquiry or verification of benefits is NOT a verification of coverage of a specific medical procedure. Verification of benefits is NOT a guarantee of payment. You can find the Accolade Member Services number on the back of Your Member Identification Card or please refer to the section titled **Healthcare Management – Precertification**

**Identity Protection Services**
If You are enrolled in an Anthem medical Plan, You automatically receive a basic level of Identity Repair Services and can voluntarily enroll in Credit and Identity Theft Monitoring Services, at no cost to You.

# MEMBER RIGHTS AND RESPONSIBILITIES

As a Member You have rights and responsibilities when receiving healthcare. As Your healthcare partner, we want to make sure Your rights are respected, while providing Your health benefits. That means giving You access to our network of Physicians and healthcare professionals, who help You make the best decisions for Your health. As a Member, You should also take an active role in Your care.

**You have the right to:**

- Speak freely and privately with Your Physicians and other healthcare professionals about healthcare options and treatment needed for Your condition no matter what the cost or whether it is covered under Your Plan.
- Work with Your Physicians and other healthcare professionals to make choices about Your health care.
- Be treated with respect and dignity.
- Expect us to keep Your personal health information private by following our privacy policies, and state and Federal laws.
- Receive information You need to fully engage with Your health Plan, and also share Your feedback. This includes:
  - Our company and services.
  - Our Network of Physicians and other healthcare professionals.
  - Your rights and responsibilities.
  - The way Your health Plan works.
- Make a complaint or file an appeal about:
  - Your health Plan and any care You receive.
  - Any Covered Service or benefit decision that Your health Plan makes.
- Say no to care, for any condition, sickness, or disease, without it having an effect on any care You may receive in the future. This includes asking Your Physicians and other healthcare professionals to tell You how that may affect Your health now and in the future.
- Get the most up-to-date information from a doctor about the cause of Your illness, Your treatment, and what may result from it. You can ask for help if You do not understand this information.
- Get help at any time, by calling the Accolade Member Services number located on the back of Your Identification Card or by visiting anthem.com.

**You have the responsibility to:**

- Read all information about Your benefits and ask for help if You have questions.
- Follow all Plan rules and policies.
- Choose a Network Primary Care Physician, also called a PCP.
- Treat all health care professionals and staff with respect.
- Keep all scheduled appointments. Call Your Physician's office if You may be late or need to cancel.
- Understand Your health challenges as well as You can and work with Your Physicians and other healthcare professionals to create an agreed upon treatment Plan.
- Inform Your Physicians and other healthcare professionals if You don't understand the type of care and Your actions that they're recommending.
- Follow the treatment plan that You have agreed upon with Your Physicians and other healthcare professionals.
- Share the information needed with us, Your Physicians and other healthcare professionals to help You get the best possible care. This may include information about other health insurance benefits You have in addition to Your coverage with us.
- If You have any changes to Your name, address or family members covered under the Plan, contact BNY Mellon Benefit Solutions Service Center at 1-855-354-6940. Representatives are available Monday through Friday between 8:30 a.m. and 8 p.m. ET. Access the MyBenefit Solutions website:
  - At Work: Single sign-on access through People Rewards (MySource > People > People Rewards > My External Links > Health > MyBenefit Solutions).

- At Home: mybenefits.bnymellon.com (If you're a new employee or have not already registered, you'll need to create a username and password).

If You would like more information, call Accolade Member Services at the number located on Your Member Identification Card.

The Claims Administrator, and Accolade, as your Employer's advocacy service vendor, want to provide high quality customer service to our Members. Benefits and coverage for services given under the Plan are governed by the Employer's Plan and not by this **Member Rights and Responsibilities** statement.

**How to Obtain Language Assistance**

**Accolade** is committed to communicating with our Members about their health Plan regardless of their language. **Accolade** employs a language line interpretation service for use by all of our Member Services Call Centers. Simply call the Accolade Member Services phone number on the back of Your Identification Card, and a representative will be able to assist You. TTY/TDD service also are available by dialing 711. A special operator will get in touch with us to help with Your needs.

# SCHEDULE OF BENEFITS – Copay Plan

If You are enrolled in the Copay Plan, the following schedule of benefits will apply:

## Welcome to the Copay Plan (a Preferred Provider Organization (PPO) Plan)!

**With the Copay Plan, You have health coverage available to You through a medical care arrangement in which Network Providers and facilities provide services at reduced rates, while also allowing access to Out-of-Network Providers. This coverage is designed to provide You flexibility and control in choosing the health care services You and Your family members receive and in choosing how the cost of these services is paid. Bottom line, the Copay Plan is designed to help You – and Your family – take control of Your health care decisions.**

The Maximum Allowed Amount is the amount the Claims Administrator will reimburse for services and supplies which meet its definition of Covered Services, as long as such services and supplies are not excluded under the Plan; are Medically Necessary; and are provided in accordance with the Plan. Please refer to the Definitions and Claims Payment sections for more information. Under certain circumstances, if the Claims Administrator pays the healthcare Provider amounts that are Your responsibility, such as Deductibles, Copayments or Coinsurance, the Claims Administrator may collect such amounts directly from You. You agree that the Claims Administrator has the right to collect such amounts from You.

**Plus – To help You stay healthy, use:**
**Preventive Services**
100% coverage for Preventive Services using Network Providers.

No Deductible or Out-of-Pocket costs for You as long as You receive Your Preventive Service from a Network Provider. If You choose to go to an Out-of-Network Provider for Preventive Service, Your Deductible and Out-of-Network Copay will apply.

**If needed:**

**Non-Preventive Services**
Coverage for Non-Preventive Service is effective once You have met an up-front Out-of-Pocket cost for covered charges (Your Deductible, or in some cases, a Copay that applies to certain circumstances). When a Copayment applies, the Deductible is waived. Unless otherwise specified in this Benefit Booklet, Covered Services for Non-Preventive Services are subject to the Deductible and applicable Coinsurance. The Non-Preventive Service is governed by the details contained elsewhere in this document.

## BNY Mellon reserves the right to amend or terminate the Plan at any time. You will be notified of any changes that affect Your benefits, as required by Federal law.

## Financial Tools

The Copay Plan offers online financial tools to help You keep track of Your health care dollars. Plus You can track Your claims for Covered Services. You can review what You have spent on health care or look up the status of a particular claim any time of the day.

**To get the highest benefits at the lowest out-of-pocket cost You must get Covered Services from a Network Provider.** Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. Except for Surprise Billing Claims, if You use an Out-of-Network Provider You may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please refer to the Claims Payment section for more details.

Coinsurance/Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

| Schedule of Benefits | Network | Out-of-Network[1] |
|---|---|---|
| **Calendar Year Deductible** | | |
| **Individual** | $500 | $1,000 |
| **Family[3]** | $1,000 | $2,000 |
| Charges in excess of the Maximum Allowed Amount do not count toward to the Deductible. | | |
| **All Covered Services are subject to the Deductible unless otherwise specified in this Benefit Booklet.** | | |
| **[3]Family applies to the Employee + Child(ren), Employee + Spouse/Qualified Domestic Partner and Employee + Family levels of coverage.**<br><br>The Copay Plan has an Individual/Family Deductible. Under an Individual/Family Deductible, once one family member meets the individual deductible, coinsurance applies for that family member only. Once one individual or a combination of family members meet the family deductible, coinsurance applies for all family members up to the Out-of-Pocket Maximum. | | |
| The Network and Out-of-Network Calendar Year Deductibles are separate and cannot be combined. | | |
| **Coinsurance After the Calendar Year Deductible is Met (Unless Otherwise Specified)**<br><br>Contact Accolade at 1-833-640-0427 if you have questions about how the Plan pays. | | |
| **Plan Pays** | 80% | 60% |
| **Member Pays** | 20% | 40% |
| All payments are based on the Maximum Allowed Amount and any negotiated arrangements. Except for Surprise Billing Claims, if You use an Out-of-Network Provider, You may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount, also known as "balance billing". Depending on the service, this difference can be substantial. | | |

*[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.*

*[2]Services may be billed differently based on the Provider (Primary Care Or Specialty Provider) or location of service. If you have any questions, please contact Accolade.*

**Out-of-Pocket Maximum Per Calendar Year**

Includes Coinsurance and Copayments and the Calendar Year Deductible. Does NOT include charges in excess of the Maximum Allowed Amount or Non-Covered Services or pre-certification penalties.

The Network and Out-of-Network Out-of-Pocket Maximums are separate and cannot be combined. Once one individual or a combination of family members meet the applicable annual family Out-of-Pocket Maximum, the Plan pays 100% of eligible medical expenses for all family members for such Network or Out-of-Network Services, as the case may be depending on which Out-of-Pocket Maximum has been met.
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| Base Pay Range | Network Out-of-Pocket Maximum | Out-of-Network Out-of-Pocket Maximum |
|---|---|---|
| **$0 - $29,999** | | |
| **Individual** | $2,100 | $4,200 |
| **Family** | $4,200 | $8,400 |
| **$30,000 - $49,999** | | |
| **Individual** | $3,400 | $6,800 |
| **Family** | $6,800 | $13,600 |
| **$50,000 - $79,999** | | |
| **Individual** | $4,600 | $9,200 |
| **Family** | $9,200 | $18,400 |
| **$80,000 - $124,999** | | |
| **Individual** | $5,800 | $11,600 |
| **Family** | $11,600 | $23,200 |
| **$125,000+** | | |
| **Individual** | $6,450 | $12,900 |
| **Family** | $12,900 | $25,800 |



*[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.*

*[2]Services may be billed differently based on the Provider (Primary Care Or Specialty Provider) or location of service. If you have any questions, please contact Accolade.*

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this booklet.** | | |
| **Acupuncture**<br>20 Visits Per calendar year combined Network and Out-of-Network | 20% | 40% |
| **Allergy Care** | | |
| Testing – Physician or Specialist Physician | 20% | 40% |
| Treatment – Physician or Specialist Physician | 20% | 40% |
| **Ambulance Services** | | |
| Ambulance Services (when Medically Necessary)<br>Air | 20% | 20% |
| Ambulance Services (when Medically Necessary)<br>Ground<br><br>**Note:** If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges. | 20% | 20% |
| **Clinical Trials[2]**<br>Please refer to Clinical Trials in the **Benefits** section for further information.<br><br>*If a member is part of an FDA-approved clinical trial for a life-threatening disease, medical expenses that are currently covered under the Plan that happen during that trial will be covered.* | 20%<br>or<br>Billed Copay | 40% |
| **Dental & Oral Surgery/TMJ Services[2]**<br>Dental<br><br>*Covered for treatment of an injury to sound and natural teeth.* | 20%<br>or<br>Billed Copay | 40% |
| Oral Surgery<br>*Includes removal of impacted teeth. Dental Anesthesia is covered only if related to a payable oral surgery.* | 20% | 40% |
| TMJ Treatment | Not Covered | Not Covered |



*[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.*

*[2]Services may be billed differently based on the Provider (Primary Care Or Specialty Provider) or location of service. If you have any questions, please contact Accolade.*

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this booklet.** | | |
| **Diagnostic Physician's Services** | | |
| Diagnostic services (including second opinion) by a Physician or Specialist Physician – office visit or home visit: | | |
| Primary Care Physician Copayment | $10 Copay per visit | 40% |
| Specialist Physician Copayment | $40 Copay per visit | 40% |
| Diagnostic X-ray and Lab – office or independent lab (Routine) | Covered at 100%, No Deductible | 40% |
| Diagnostic X-ray and Lab – office or independent lab (Non-Routine) | 20% | 40% |
| High Diagnostic Imaging (including MRIs, CAT scans) | 20% | 40% |
| **Note: Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.** | | |
| **Emergency Room and Urgent Care** | | |
| Emergency Room<br>*Prudent Layperson guidelines apply.*<br>*If admitted, the Emergency Room copay is waived.* | $250 Copay per visit | $250 Copay per visit, No Deductible |
| Urgent Care | $75 Copay per visit | 40% |
| **Note: Care received Out-of-Network for an Emergency Medical Condition will be provided at the Network level of benefits if the following conditions apply:** A medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:<br>(1) Placing the health of the individual or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;<br>(2) Serious impairment to bodily functions; or<br>(3) Serious dysfunction of any bodily organ or part.<br><br>If an Out-of-Network Provider is used, claims for Emergency services will be covered at the Network benefit level; however, You may be billed the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges, unless Your claim is a Surprise Billing Claim. If the Provider bills You for this additional amount, please call Accolade Member Services at the number on the back of your Member Identification Card for the claim to be reviewed. | | |



*[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.*

*[2]Services may be billed differently based on the Provider (Primary Care Or Specialty Provider) or location of service. If you have any questions, please contact Accolade.*

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this booklet.** | | |
| As described in the **Consolidated Appropriations Act of 2021 Notice** in the **Health Benefits Coverage Under Federal Law** section, with respect to Emergency services Out-of-Network Providers may only bill You for any applicable Copayments, Deductible and Coinsurance and may not bill You for any charges over the Plan's Maximum Allowed Amount until the treating Out-of-Network Provider has determined You are stable. Please refer to the Notice in the **Health Benefits Coverage Under Federal Law** section for more details. **Explanation of Benefits (EOB) Message:** EOB will confirm this claim has been processed at the Network benefit level. If the Provider bills You for an additional amount, please call Accolade Member Services at the *number on the back of your Member Identification Card for the* claim to be reviewed to allow payment up to the Provider's billed charges. You will need to provide a copy of the Explanation of Benefits and the Provider's bill as part of the review. Make sure Your Member Identification number is on the bill. | | |
| **Eye Care - Non-Routine** | | |
| Office Visit – medical eye care exams (treatment of disease or Injury to the eye) | | |
| Primary Care Physician | $10 Copay per visit | 40% |
| Specialist Physician | $40 Copay per visit | 40% |
| Treatment other than office visit | 20% | 40% |
| Routine eye exams are not a Covered Service. | | |
| **Gene Therapy Services[2]**<br>• Precertification required | 20%<br>or<br>Billed Copay | 40% |
| **Hearing Care - Non-Routine** | | |
| Office Visit – Audiometric exam/hearing evaluation test | | |
| Primary Care Physician | $10 Copay per visit | 40% |
| Specialist Physician | $40 Copay per visit | 40% |
| Hearing Devices/Hearing Aids[2]<br>*Including exams and hearing aid accessories.*<br>*Limit $5,000 Every 24 Months*<br>**Refer to SpecialOffers discounts in Additional Programs Solutions section for hearing aid discounts available.** | 20%<br>or<br>Billed Copay | 40% |
| Routine hearing exams are not a Covered Service. | | |



*[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.*

*[2]Services may be billed differently based on the Provider (Primary Care Or Specialty Provider) or location of service. If you have any questions, please contact Accolade.*

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this booklet.** | | |
| **Home Health Care Services**<br>*60 visits per calendar year combined Network and Out-of-Network. The limit is combined with Private Duty Nursing* | 20% | 40% |
| **Private Duty Nursing**<br>*60 visits per calendar year combined Network and Out-of-Network. The limit is combined with Home Health Care Services* | 20% | 40% |
| **Hospice Care Services** | 20% | 40% |
| **Hospital Inpatient Services – Precertification Required** | | |
| Hospital Services and Supplies<br>• Inpatient Physical Medical Rehab<br>*120 days per Plan Year combined Network and Out-of-Network. Combined Skilled Nursing Facility and Inpatient Medical Rehab.* | 20% | 40% |
| Pre-Admission Testing | 20% | 40% |
| Physician Services*: | | |
| ➢ Assistant Surgeon | 20% | 40% |
| ➢ Anesthesiologist | 20% | 40% |
| ➢ Radiologist | 20% | 40% |
| ➢ Pathologist | 20% | 40% |

**Note:** *Assistant surgeon, anesthesiologist, radiologist, pathologist and emergency room physician Services rendered by Out-of-Network Providers in a Network hospital setting are covered at the Network level of benefits. You may be billed the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges except for Surprise Billing Claims. If the Provider bills You for this additional amount, please call Accolade Member Services at the number on the back of your Member Identification Card for the claim to be reviewed.

**Explanation of Benefits (EOB) Message:** EOB will confirm this claim has been processed at the Network benefit level. If the Provider bills You for an additional amount, please call Accolade Member Services at the number on the back of your Identification card for the claim to be reviewed to allow payment up to the Provider's billed charge. You will need to provide a copy of this Explanation of Benefits and the Provider's bill as part of the review. Make sure Your Member Identification number is on the bill.



*[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.*

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| | Network | Out-of-Network[1] |
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| **Maternity Care** | | |
| Inpatient | 20% | 40% |
| Lactation Consultations | First 6 visits: Covered at 100%<br>Additional visits: 20% | 40% |
| Global Maternity Charges Office Professional Visit<br>*Network: 1st 40% of Global maternity charges covered at 100%, remaining 60% is covered subject to Deductible and Coinsurance.*<br>*Out-of-Network: maternity charges covered at Out-of-Network Deductible and Coinsurance.*<br>**Note:** Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48 hours for a vaginal delivery or 96 hours for a cesarean section, must be pre-certified. | $10 Copay per pregnancy | 40% |
| **Fertility Services**<br>*Treatment covered only when performed in a Blue Distinction Center/Blue Distinction Center+ Facility.* | | |
| Diagnostic Services[2] | 20%<br>or<br>Billed Copay | 40% |
| Fertility Services have a combined Medical and Pharmacy Lifetime Maximum | $50,000 Per Lifetime Network only | |
| Treatment | 20% | Not Covered |
| Elective egg/sperm cryopreservation coverage – 1 year of storage<br>*Services must be obtained through a Blue Distinction Center/Blue Distinction Center + if there is one located within 50 miles of Member's home. If there is not a Blue Distinction Center/Blue Distinction Center + within 50 miles of Member's home, contact Accolade in advance of obtaining the Covered Service in order to get approval for a Network Provider (non-BDC+/BDC Facility) to be used.*<br>*Covered Services include but are not limited to: in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination.* | | |



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| | Network | Out-of-Network[1] |
| **Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this booklet.** | | |
| **Sterilization Services (Precertification required for Inpatient procedures)** | 20%<br>or<br>Billed Copay | 40% |
| Sterilizations for women will be covered under the "Preventive Services" benefit. Please refer to that section in **Benefits** for further details. | | |
| **Medical Supplies and Equipment** | | |
| Medical Supplies | 20% | 40% |
| Durable Medical Equipment | 20% | 40% |
| Orthotics<br>*Wigs/Toupees limited to 1 per year, subject to Medical Necessity.*<br>*Includes Foot Orthotics based on Medical Necessity.* | 20% | 40% |
| Hearing Aid Services<br>*Including exams and hearing aid accessories.*<br>*Limit: $5,000 every 24 months combined Network and Out-of-Network*<br>**Refer to SpecialOffers discounts in Additional Programs Solutions section for hearing aid discounts available.** | 20% | 40% |
| **Mental Health/Substance Abuse Care** | | |
| Hospital Inpatient Services | 20% | 40% |
| Outpatient Services | $10 Copay per visit | 40% |
| Physician Services | $10 Copay per visit | 40% |



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*[2]Services may be billed differently based on the Provider (Primary Care Or Specialty Provider) or location of service. If you have any questions, please contact Accolade.*

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| Applied Behavioral Analysis (ABA) Therapy[2] | 20%<br>or<br>Billed Copay | 40% |
| **Note: Coverage for the treatment of Mental Health and Substance Abuse Care conditions is provided in compliance with Federal law.** | | |
| **Nutritional Counseling for Diabetes** | 20% | 40% |
| **Nutritional Counseling (Non-Diabetic)**<br>*Limit: 6 visits per year combined Network and Out-of-Network*<br>*Covered for eating disorders with no visit limit.* | 20% | 40% |
| **Outpatient Hospital/Facility Services** | | |
| Outpatient Facility | 20% | 40% |
| Lab and X-Ray Services | 20% | 40% |
| Outpatient Physician Services (surgeon, anesthesiologist, radiologist, pathologist, etc.) | 20% | 40% |
| **Physician Services (Home and Office Visits)** | | |
| Primary Care Physician | $10 Copay per visit | 40% |
| Specialist Physician | $40 Copay per visit | 40% |
| Virtual Primary Care visits with Primary Care Providers through the Sydney Health mobile app with features such as a symptom checker, secure medical text chats, customized care plans, and referrals. | Covered at 100%,<br>No Deductible | Not Applicable |
| Virtual Video Visits (LiveHealth Online)<br>*Medical and Mental Health is covered at 100%, no Deductible.* | Covered at 100%,<br>No Deductible | Not Applicable |
| Telehealth<br>Consultations with Your Provider (PCP/Specialist) using visual and audio (Computer, Smart Phone, Tablet)<br>**Network Mental Health is covered at $10 Copay. Network Medical is covered at PCP or Specialist Copay.* | $10 Copay PCP<br>$40 Copay Specialist * | 40% |



*[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.*

*[2]Services may be billed differently based on the Provider (Primary Care Or Specialty Provider) or location of service. If you have any questions, please contact Accolade.*

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this booklet.** | | |
| Telephonic<br>Consultations with Your Provider (PCP/Specialist) using audio only (telephone)<br>**Network Mental Health is covered at $10 Copay. Network Medical is covered at PCP or Specialist Copay.* | $10 Copay PCP<br>$40 Copay Specialist * | 40% |
| **COVID Benefits**<br><br>* NOTE: If the Provider bills You for an additional amount, please call Accolade Member Services at the number on the back of your Identification card for the claim to be reviewed to allow payment up to the Provider's billed charge. | | |
| Testing - through 5/11/2023 when the Public Health Emergency ends.<br>*Includes COVID Testing, Rapid Tests and Diagnosis based on Medical Necessity.* | Covered at 100%, No Deductible | Covered at 100%, No Deductible* |
| *Testing received after 5/11/2023 will be covered* subject to the standard benefit provisions for both In-Network and Out-of-Network. | 20% | 40% |
| All other benefits related to COVID treatment are subject to the standard benefit provisions. | | |
| **Preventive Services**<br>**(Includes Virtual Primary Care Visits)** | **Covered at 100%, No Deductible** | 40% |
| **Skilled Nursing Facility** | 20% | 40% |
| **Limit Maximum days** | 120 days per Plan year combined Network and Out-of-Network. Combined Skilled Nursing Facility and Inpatient Medical Rehab. | |
| **Abortion (Therapeutic and Voluntary Termination of Pregnancy)** | 20% | 40% |
| **Gender Affirming Surgery[2]** | 20%<br>or<br>Billed Copay | 40% |
| **Bariatric Surgery**<br><br>Covered only when performed in a Blue Distinction Center Facility. | 20% | Not Covered |



*[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.*

*[2]Services may be billed differently based on the Provider (Primary Care Or Specialty Provider) or location of service. If you have any questions, please contact Accolade.*

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this booklet.** | | |
| For the Covered Bariatric Procedure, You will pay 20% when using a Blue Distinction Center + and Blue Distinction Center Facility.<br><br>Members will be required to go to a Bariatric Blue Distinction Center / *Blue Distinction Center* + for bariatric surgery if one is located within 50 miles of the Member's home. If a Bariatric Blue Distinction Center / *Blue Distinction Center* + is available within 50 miles of the Member's home and the Member does not use one, the Member will pay the full cost of the surgery. Services must be obtained through a Bariatric Blue Distinction Center / *Blue Distinction Center* + if there is one located within 50 miles of Member's home. If there is not a Bariatric Blue Distinction Center / *Blue Distinction Center* + within 50 miles of Member's home, contact Accolade in advance of obtaining the Covered Service in order to get approval for a Network Provider (non-BDC+/BDC Facility) to be used.<br><br>**PAR Bariatric Surgery (non-BDC+/BDC Provider) and Out-of-Network Bariatric Provider:** There is NO benefit. | | |
| **Blue Distinction Centers+/Blue Distinction Centers Transplant Surgery Benefit**<br><br>Members will be required to go to a Kidney Blue Distinction Center or Centers of Medical Excellence for Kidney Transplants if one is located within 50 miles of the Member's home. If a Kidney Blue Distinction Center or Centers of Medical Excellence is available within 50 miles of the Member's home and the Member does not use one, the Member will pay the full cost of the surgery. Services must be obtained through a Kidney Blue Distinction Center / Blue Distinction Center + if there is one located within 50 miles of Member's home. If there is not a Kidney Blue Distinction Center / Blue Distinction Center + within 50 miles of Member's home, contact Accolade in advance of obtaining the Covered Service in order to get approval for a Network Provider (non-BDC+/BDC Facility) to be used.<br><br>Services must be obtained through a Blue Distinction Center / Blue Distinction Center + for transplants if there is one located within 50 miles of Member's home. If there is not a Blue Distinction Center / Blue Distinction Center + within 50 miles of Member's home, contact Accolade in advance of obtaining the Covered Service in order to get approval for a Network Provider (non-BDC+/BDC Facility) to be used. | | |

| | | | |
|---|---|---|---|
| **Designated BDC+ Provider for Transplant Surgery Procedures** | **Designated BDC Provider for Transplant Surgery procedures** | **PAR (Network) Transplant Provider (non-BDC+/BD Provider)** | **Non-PAR (Out-of-Network) Transplant Provider** |
| | | | |
| **Benefit Limits for Covered Transplant Procedure:** | | | |
| For the Covered **Transplant** Procedure, You will pay **20%** of the Maximum Allowed Amount when using a designated **BDC+** Provider. This benefit includes services directly related to the | For the Covered **Transplant** Procedure, You will pay **20%** of the Maximum Allowed Amount when using a designated **BDC** Provider. This benefit includes services directly related to the | Not Covered | Not Covered |



*[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.*

*[2]Services may be billed differently based on the Provider (Primary Care Or Specialty Provider) or location of service. If you have any questions, please contact Accolade.*

| Benefits | | Member Responsibility | |
|---|---|---|---|
| | | Network | Out-of-Network[1] |
| **Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this booklet.** | | | |
| covered procedure (Facility, professional and ancillary services) during the Inpatient or outpatient stay. If the service is NOT directly related to the covered procedure, services will be covered based on Your standard medical benefit. | covered procedure (Facility, professional and ancillary services) during the Inpatient or outpatient stay. If the service is NOT directly related to the covered procedure, services will be covered based on Your standard medical benefit. | | |
| | | | |
| **Deductibles** | | | |
| Deductibles apply | Deductibles apply | Not Covered | Not Covered |
| | | | |
| **Live Donor Searches** | | | |
| Covered at 20% subject to Deductible.<br><br>Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement. | Covered at 20% subject to Deductible.<br><br>Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement. | Not Covered | Not Covered |
| | | | |
| **Bone Marrow Donor Search** | | | |
| Bone Marrow Donor Search fees are covered up to a maximum of $30,000 per transplant | Bone Marrow Donor Search fees up to a maximum of $30,000 per transplant | Not Covered | Not Covered |
| | | | |
| **Organ Transplants (institutional)** | | | |
| Donor expenses are covered at **20%** of Maximum Allowed Amount | Donor expenses are at **20%** of Maximum Allowed Amount | Not Covered | Not Covered |
| | | | |
| **Organ Transplants (professional)** | | | |
| Donor expenses are covered at **20%** of Maximum Allowed Amount | Donor expenses are at **20%** of Maximum Allowed Amount | Not Covered | Not Covered |



*[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.*

*[2]Services may be billed differently based on the Provider (Primary Care Or Specialty Provider) or location of service. If you have any questions, please contact Accolade.*

| Benefits | | Member Responsibility | |
|---|---|---|---|
| | | Network | Out-of-Network[1] |
| **Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this booklet.** | | | |
| **Organ Transplant Travel Reimbursement** | | | |
| Covered, as approved by the Claims Administrator, for applicable transportation and lodging expenses. Prior approval is required. Subject to a maximum of $10,000 per transplant. Must live at least 50 miles from transplant facility. | Covered, as approved by the Claims Administrator, for applicable transportation and lodging expenses. Prior approval is required. Subject to a maximum of $10,000 per transplant. Must live at least 50 miles from transplant facility. | Not Covered | Not Covered |

Contact Accolade Member Services for detailed information regarding organ transplant travel reimbursements. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Exclusions include:

- Meals - Restaurants & Take Out: Meals and snacks
- Food & beverage
- Valet parking
- Convenience items: telephone, fax
- Entertainment items: movies, books, and video rentals
- Furnishing for apartments: cooking utensils, appliances, furniture
- Groceries: Alcohol, cigarettes, paper products, toiletries; personal hygiene products
- Laundry service or dry cleaning
- Laundry detergent
- Gratuities of any kind
- Moving trucks (e.g. U-Haul)

| **Blue Distinction Orthopedic Surgery Benefit** | | | |
|---|---|---|---|
| **Designated BDC+ Provider for Knee/Hip Replacements & Spine Surgery Procedures** | **Designated BDC Provider for Knee/Hip Replacements & Spine Surgery Procedures** | **PAR (Network) Orthopedic Provider (non-BDC+/BDC Provider)** | **Non-PAR (Out-of-Network) Orthopedic Provider** |
| **Benefit Limits for Covered Orthopedic Procedures:** | | | |
| For the Covered Orthopedic Procedure, You will pay **0%** of the Maximum Allowed Amount when using a designated **BDC+** | For the Covered Orthopedic Procedure, You will pay **0%** of the Maximum Allowed Amount when using a designated **BDC** | For the Covered Orthopedic Procedure, You will pay **20%** of the Maximum Allowed Amount when using a **PAR** Network Provider. | For the Covered Orthopedic Procedure, You will pay **40%** of the Maximum Allowed Amount when using a |



*[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.*

*[2]Services may be billed differently based on the Provider (Primary Care Or Specialty Provider) or location of service. If you have any questions, please contact Accolade.*

| Benefits | | Member Responsibility | |
|---|---|---|---|
| | | Network | Out-of-Network[1] |
| **Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this booklet.** | | | |
| Provider. This benefit includes services directly related to the covered procedure (Facility, professional and ancillary services) during the Inpatient or outpatient stay. If the service is NOT directly related to the covered procedure, services will be covered based on Your standard medical benefit | Provider. This benefit includes services directly related to the covered procedure (Facility, professional and ancillary services) during the Inpatient or outpatient stay. If the service is NOT directly related to the covered procedure, services will be covered based on Your standard medical benefit | As the Provider is PAR (Network), You will NOT be responsible for amounts that exceed the Maximum Allowed Amount (You will NOT be required to pay any amounts due to Providers after Your health Plan benefits have been applied, beyond Your standard Out-of-Pocket costs). | **non-PAR** Out- of-Network Provider. As the Provider is non-PAR (Out-of-Network), You WILL be responsible for amounts that exceed the Maximum Allowed Amount (You WILL be required to pay any amounts due to Providers after Your health Plan benefits have been applied). |
| | | | |
| **Deductibles:** | | | |
| Network Deductibles apply | Network Deductibles apply | Network Deductibles apply | Out-of-Network Deductibles will apply. |
| | | | |
| **Therapy Services (Outpatient)** | | | |
| Physical Therapy* | | $40 Copay per visit | 40% |
| Occupational Therapy* | | $40 Copay per visit | 40% |
| Speech Therapy* | | $40 Copay per visit | 40% |
| Cardiac Rehabilitation | | 20% | 40% |
| Manipulation Therapy | | $40 Copay per visit | 40% |
| *Limit: 24 visits per year (Combined Network and Out-of-Network) Copay applies to Manipulations and Therapy charges.* | | | |
| Radiation Therapy | | 20% | 40% |
| Chemotherapy | | 20% | 40% |
| Respiratory Therapy | | 20% | 40% |
| Vision Therapy | | 20% | 40% |



*[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.*

*[2]Services may be billed differently based on the Provider (Primary Care Or Specialty Provider) or location of service. If you have any questions, please contact Accolade.*

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this booklet.** | | |
| ***Combined Limit –** Benefits for Physical Therapy, Occupational Therapy, Speech Therapy, are limited to 60 visits per Plan year, combined Network and Out-of-Network. Additional visits may be approved based on Medical Necessity.<br>Autism Diagnosis are not included in the visit limit. | | |
| **Travel Reimbursement**<br>**(All Services excluding Organ Transplants)** | Covered at 100%,<br>No Deductible | Not Covered |

Travel reimbursement rules for organ transplants are provided above under "Organ Transplant Travel Reimbursement". This section applies to travel reimbursements for all other Covered Services. Unless as prohibited by law, the Claims Administrator will cover reasonable and necessary travel costs when You are required to travel to another state to obtain Covered Services that are not available within Your state of residence.

Travel and Lodging Expenses may be available for services received at a Network provider. Accolade will assist the patient and family with travel and lodging reimbursement when the Member is unable to locate a Network or Out of Network provider within their state of residence. Eligibility can be confirmed with Accolade per the rules listed in this document. Expenses for travel and lodging for the recipient and a companion should be verified by working with Accolade to obtain the specific travel reimbursement claim form. Travel Reimbursement may be available as follows:

- Transportation is covered, including expenses for personal car mileage at the current Federal rate of reimbursement, of the patient and one companion who is traveling on the same day(s) to and/or from the site of the surgery for an evaluation, the procedure, or necessary post-discharge follow-up;
- Reasonable and necessary expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per-diem rate of $50 for one person or $100 a day for two people (a maximum of $50 per person — $100 for patient and companion combined — per night is paid toward lodging expenses. To qualify for the $100 per day, the companion must be serving as a caregiver to the patient; meals are not covered;
- Travel and lodging expenses are available only for Network Medical services that are not available in the covered member's state of residence from any provider (Network or Out of Network).
- If the patient is a covered Dependent minor child, the travel expenses of two companions will be covered; lodging expenses will be reimbursed at the $100 per-diem rate.
- These benefits are subject to a maximum of $1,000 per member and adult companion(s), per occurrence, for all covered transportation and lodging expenses incurred by the Member receiving the service and companion (two primary guardians, if the covered Dependent is a minor), and reimbursed under the Plan. No annual or lifetime limits.
- For information about the transportation and lodging benefits, please contact Accolade Member Services at 1-833-640-0427.



*[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.*

*[2]Services may be billed differently based on the Provider (Primary Care Or Specialty Provider) or location of service. If you have any questions, please contact Accolade.*

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this booklet.** | | |
| The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Claims Administrator when the qualifying Medical claim is on file. Contact Accolade Member Services for detailed information. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.<br><br>Exclusions include:<br><br>• Meals - Restaurants & Take Out: Meals and snacks<br>• Food & beverage<br>• Valet parking<br>• Convenience items: telephone, fax<br>• Entertainment items: movies, books, and video rentals<br>• Furnishing for apartments: cooking utensils, appliances, furniture<br>• Groceries: Alcohol, cigarettes, paper products, toiletries; personal hygiene products<br>• Laundry service or dry cleaning<br>• Laundry detergent<br>• Gratuities of any kind<br>• Moving trucks (e.g. U-Haul) | | |



*[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.*

*[2]Services may be billed differently based on the Provider (Primary Care Or Specialty Provider) or location of service. If you have any questions, please contact Accolade.*

# SCHEDULE OF BENEFITS - LOWER DEDUCTIBLE AND HIGHER DEDUCTIBLE HSA PLANS

If You are enrolled in either the Lower Deductible or Higher Deductible HSA Plan, the following schedule of benefits will apply, as applicable:

## Welcome to the Health Savings Account (HSA) Plan!

With the Lower Deductible and Higher Deductible HSA Plans (collectively, the "HSA Plans"), You have health coverage available to You for which You and the Plan share the cost. This coverage has two components designed to work together to provide You flexibility and control in choosing the health care services You and Your family members receive and in choosing how the cost of these services is paid. Bottom line, the HSA Plans are designed to help You – and Your family – take control of Your health care dollars and decisions.

The Maximum Allowed Amount is the amount the Claims Administrator will reimburse for services and supplies which meet its definition of Covered Services, as long as such services and supplies are not excluded under the Member's Plan. See the **Definitions** and **Claims Payment** sections for more information.

Under certain circumstances, if the Claims Administrator pays the healthcare Provider amounts that are Your responsibility, such as Deductibles, Coinsurance, the Claims Administrator may collect such amounts directly from You. You agree that the Claims Administrator has the right to collect such amounts from You.

## How the HSA Plans Work

The HSA Plans are an innovative approach to health benefits that puts You in charge of the money You spend for health care services and helps You get the most out of Your company-sponsored health coverage. With the HSA Plans, You have flexibility and control in choosing the health care services You and Your family members receive – and in determining how the cost of these services is paid.

## The HSA Plans – In Brief

**First** – Using Your Health Savings Account ("HSA") to pay for Covered Services:

**Health Savings Account**
With the HSA, You can contribute pre-tax dollars to Your HSA. Others may also contribute dollars to Your account. You can use the dollars to help meet Your annual Deductible responsibility. Unused dollars can be saved or invested and accumulate through retirement.

**Plus – To help You stay healthy, use:**
**Preventive Services**
100% coverage for Preventive Services using Network Providers.

No deductions from the HSA or Out-of-Pocket costs for You as long as You receive Your Preventive Services from a Network Provider. If You choose to go to an Out-of-Network Provider for Preventive Services, Your Deductible or Non-Preventive Service benefits will apply.

**If needed:**

**Non-Preventive Services**
Coverage for Non-Preventive Service is effective once You have met an up-front Out-of-Pocket cost for covered charges (Your Deductible). Once coverage is effective, the Plan will reimburse a percentage of the cost for Covered Services. You will be responsible for covering the remainder of the expense of Covered Services, up to an annual Out-of-Pocket Maximum. After this amount has been met, You will receive coverage for Covered Services for the remainder of the Plan year as specified elsewhere in this Benefit Booklet. The Non-Preventive Service Benefit is governed by the details contained elsewhere in this document.

**BNY Mellon reserves the right to amend or terminate the Plan at any time. You will be notified of any changes that affect Your benefits, as required by Federal law.**

## Financial Tools

The HSA Plans offer online financial tools to help You keep track of Your health care dollars. Plus You can track Your claims for Covered Services. You can review what You have spent on health care or look up the status of a particular claim any time of the day.

**To get the highest benefits at the lowest out-of-pocket cost, you must get Covered Services from a Network Provider.** Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. Except for Surprise Billing Claims, if You use an Out-of-Network Provider You may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please refer to the **Claims Payment** section for more details.

Coinsurance/Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

**Contributions to Your HSA**

You may be eligible to contribute and/or receive BNY Mellon contributions to your HSA. Information regarding contributions for 2023, is available on MySource at People > Benefits > 2023 Benefits Guide. For general questions about your HSA, contact Accolade at 1-833-640-0427. For specific questions about your Benefit Wallet HSA account, contact Benefit Wallet at 1-877-472-4200, or go to mybenefitwallet.com.



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

# Lower Deductible HSA Plan

If You are enrolled in the Lower Deductible HSA Plan, the following Schedule of Benefits shall apply.

| Schedule of Benefits | Network | Out-of-Network[1] |
|---|---|---|
| **Calendar Year Deductible** | | |
| **Individual** | $1,500 | $3,000 |
| **Family[3]** | $3,000 | $6,000 |
| Charges in excess of the Maximum Allowed Amount do not count towards the Deductible. | | |
| **All Covered Services are subject to the Deductible unless otherwise specified in this Benefit Booklet.** | | |
| **Family applies to the Employee + Child(ren), Employee + Spouse/Qualified Domestic Partner and Employee + Family levels of coverage.**<br><br>**[3]The Plan has a True Family Deductible.** Under a true family deductible, if only one family member becomes ill or injured, that person must meet the family deductible (rather than the individual deductible) before the Plan pays for benefits. In this case, the Plan requires satisfaction of the family deductible before any coinsurance will be paid. | | |
| The Network and Out-of-Network **Calendar** year Deductibles are separate and cannot be combined. | | |
| **Coinsurance After the Calendar Year Deductible is Met (Unless Otherwise Specified)**<br><br>Contact Accolade at 1-833-640-0427 if you have questions about how the Plan pays. | | |
| **Plan Pays** | 80% | 60% |
| **Member Pays** | 20% | 40% |
| All payments are based on the Maximum Allowed Amount and any negotiated arrangements. Except for Surprise Billing Claims, if You use an Out-of-Network Provider, You may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount, also known as "balance billing". Depending on the service, this difference can be substantial. | | |
| **Out-of-Pocket Maximum Per Calendar Year**<br><br>Includes Coinsurance and the Calendar year Deductible. Does NOT include charges in excess of the Maximum Allowed Amount or Non-Covered Services.<br><br>The Network and Out-of-Network Out-of-Pocket Maximums are separate and cannot be combined. Once one individual or a combination of family members meet the applicable annual family Out-of-Pocket Maximum, the Plan pays 100% of eligible medical expenses for all family members for such Network or Out-of-Network Services, as the case may be depending on which Out-of-Pocket Maximum has been met. | | |



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Base Pay Range | Network Out-of-Pocket Maximum | Out-of-Network Out-of-Pocket Maximum |
|---|---|---|
| **$0 - $29,999** | | |
| **Individual** | $2,100 | $4,200 |
| **Family** | $4,200 | $8,400 |
| **$30,000 - $49,999** | | |
| **Individual** | $3,400 | $6,800 |
| **Family** | $6,800 | $13,600 |
| **$50,000 - $79,999** | | |
| **Individual** | $4,600 | $9,200 |
| **Family[2]** | $9,200 | $18,400 |
| **$80,000 - $124,999** | | |
| **Individual** | $5,800 | $11,600 |
| **Family[2]** | $11,600 | $23,200 |
| **$125,000+** | | |
| **Individual** | $6,450 | $12,900 |
| **Family[2]** | $12,900 | $25,800 |

[2]Out-of-Pocket expenses paid for an individual with family coverage are limited to no more than $7,900 for Network coverage before the Plan pays 100 percent of eligible medical expenses.



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | |
| **Acupuncture**<br>20 Visits Per calendar year combined Network and Out-of-Network | 20% | 40% |
| **Allergy Care** | | |
| Testing – Physician or Specialist Physician | 20% | 40% |
| Treatment – Physician or Specialist Physician | 20% | 40% |
| **Ambulance Services** | | |
| Ambulance Services (when Medically Necessary)<br>Air | 20% | 20% |
| Ambulance Services (when Medically Necessary)<br>Ground | 20% | 20% |
| **Note:** If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges. | | |
| **Clinical Trials**<br>Please refer to Clinical Trials in the **Benefits** section for further information.<br>*If a member is part of an FDA-approved clinical trial for a life-threatening disease, medical expenses that are currently covered under the plan that happen during that trial will be covered.* | 20% | 40% |
| **Dental & Oral Surgery/TMJ Services**<br>Dental<br>*Covered for treatment of an injury to sound and natural teeth.*<br>. | 20% | 40% |
| Oral Surgery<br>*Includes removal of impacted teeth. Dental Anesthesia is covered only if related to a payable oral surgery.* | 20% | 40% |
| TMJ Treatment | Not Covered | Not Covered |
| **Diagnostic Physician's Services** | | |
| Diagnostic services (including second opinion) by a Physician or Specialist Physician – office visit or home visit: | | |
| Primary Care Physician | 20% | 40% |



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | |
| Specialist Physician | 20% | 40% |
| Diagnostic X-ray and Lab – office or independent lab (Routine) | Covered at 100%, No Deductible | 40% |
| Diagnostic X-ray and Lab – office or independent lab (Non-Routine) | 20% | 40% |
| High Diagnostic Imaging (including MRIs, CAT scans) | 20% | 40% |
| **Note: Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.** | | |
| **Emergency Room and Urgent Care** | | |
| Emergency Room | 20% | 20% |
| *Prudent Layperson guidelines apply*. | | |
| Urgent Care | 20% | 40% |

**Note: Care received Out-of-Network for an Emergency Medical Condition will be provided at the Network level of benefits if the following conditions apply:** A medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:
(1) Placing the health of the individual or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
(2) Serious impairment to bodily functions; or
(3) Serious dysfunction of any bodily organ or part.

If an Out-of-Network Provider is used for Emergency services, claims will be covered at the Network benefit level, however, You may be billed the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges, unless Your claim is a Surprise Billing Claim. If the Provider bills You for this additional amount, please call Accolade Member Services at the number on the back of your Member Identification Card for the claim to be reviewed.

As described in the **Consolidated Appropriations Act of 2021 Notice** in the **Health Benefits Coverage Under Federal Law** section, Out-of-Network Providers may only bill You for any applicable Deductible and Coinsurance and may not bill You for any charges over the Plan's Maximum Allowed Amount until the treating Out-of-Network Provider has determined You are stable. . Please refer to the Notice in the **Health Benefits Coverage Under Federal Law** section for more details.

**Explanation of Benefits (EOB) Message:** EOB will confirm this claim has been processed at the Network benefit level. If the Provider bills You for an additional amount, please call Accolade Member Services at the number on the back of your Member Identification Card for the claim to be reviewed to allow payment up to the Provider's billed charges. You will need to provide a copy of the Explanation of Benefits and the Provider's bill as part of the review. Make sure Your Member Identification number is on the bill.



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | |
| **Eye Care - Non-Routine** | | |
| Office Visit – medical eye care exams (treatment of disease or Injury to the eye) | | |
| Primary Care Physician | 20% | 40% |
| Specialist Physician | 20% | 40% |
| Treatment other than office visit | 20% | 40% |
| Routine eye exams are not a Covered Service. | | |
| **Gene Therapy Services**<br>• Precertification required | 20% | 40% |
| **Hearing Care - Non-Routine** | | |
| Office Visit – Audiometric exam/hearing evaluation test | | |
| Primary Care Physician | 20% | 40% |
| Specialist Physician | 20% | 40% |
| Hearing Devices/Hearing Aids<br>*Including exams and hearing aid accessories.*<br>*Limit $5,000 Every 24 Months*<br>**Refer to SpecialOffers discounts in Additional Programs Solutions section for hearing aid discounts available.** | 20% | 40% |
| Routine hearing exams are not a Covered Service. | | |
| **Home Health Care Services**<br>*60 visits per calendar year combined Network and Out-of-Network.*<br>*The limit is combined with Private Duty Nursing* | 20% | 40% |
| **Private Duty Nursing**<br>*60 visits per calendar year combined Network and Out-of-Network.*<br>*The limit is combined with Home Health Care Services* | 20% | 40% |
| **Hospice Care Services** | 20% | 40% |
| **Hospital Inpatient Services – Precertification Required** | | |



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | |
| Room and Board (Semiprivate or ICU/CCU) | 20% | 40% |
| Hospital Services and Supplies<br>• Inpatient Physical Medical Rehab<br>*120 days per Plan year combined Network and Out-of-Network. Combined Skilled Nursing Facility and Inpatient Medical Rehab.* | 20% | 40% |
| Pre-Admission Testing | 20% | 40% |
| Physician Services*: | | |
| ► Assistant Surgeon | 20% | 40% |
| ► Anesthesiologist | 20% | 40% |
| ► Radiologist | 20% | 40% |
| ► Pathologist | 20% | 40% |
| **Note:** *Assistant surgeon, anesthesiologist, radiologist, pathologist and emergency room physician services rendered by Out-of-Network Providers in a Network hospital setting are covered at the Network level of benefits; however, You may be billed the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges, unless Your claim is a Surprise Billing Claim. If the Provider bills You for this additional amount, please call Accolade Member Services at the number on the back of your Member Identification Card for the claim to be reviewed.<br><br>**Explanation of Benefits (EOB) Message:** EOB will confirm this claim has been processed at the Network benefit level. If the Provider bills You for an additional amount, please call Accolade Member Services at the number on the back of your Member Identification Card for the claim to be reviewed to allow payment up to the Provider's billed charges. You will need to provide a copy of the Explanation of Benefits and the Provider's bill as part of the review. Make sure Your Member Identification number is on the bill. | | |
| **Maternity Care** | | |
| Inpatient | 20% | 40% |
| Lactation Consultations | First 6 visits:<br>Covered at 100%<br>Additional visits: 20% | 40% |



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | |
| Global Maternity Charges Office Professional Visit<br>*Network: 1st 40% of Global maternity charges covered at 100%, remaining 60% is covered subject to Deductible and Coinsurance.*<br>*Out-of-Network: maternity charges covered at Out-of-Network Deductible and Coinsurance.*<br>**Note:** Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48 hours for a vaginal delivery or 96 hours for a cesarean section, must be pre-certified. | 20% | 40% |
| **Fertility Services**<br>*Treatment covered only when performed in a Blue Distinction Center/Blue Distinction Center+ Facility.* | | |
| Diagnostic Services | 20% | 40% |
| Fertility Services have a combined Medical and Pharmacy Lifetime Maximum | $50,000 Per Lifetime | Network Only |
| Treatment<br>Elective egg/sperm cryopreservation coverage – 1 year of storage<br>*Services must be obtained through a Blue Distinction Center/Blue Distinction Center + if there is one located within 50 miles of Member's home. If there is not a Blue Distinction Center/Blue Distinction Center + within 50 miles of Member's home, contact Accolade in advance of obtaining the Covered Service in order to get approval for a Network Provider (non-BDC+/BDC Facility) to be used.*<br>*Covered Services include but are not limited to: in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination.* | 20% | Not Covered |
| **Sterilization Services (Precertification required for Inpatient procedures)** | 20% | 40% |
| Sterilizations for women will be covered under the "Preventive Services" benefit. Please refer to that section in **Benefits** for further details. | | |
| **Medical Supplies and Equipment** | | |
| Medical Supplies | 20% | 40% |
| Durable Medical Equipment | 20% | 40% |
| Orthotics | 20% | 40% |



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | |
| *Wigs/Toupees limited to 1 per year, subject to Medical Necessity.*<br>*Includes Foot Orthotics based on Medical Necessity.* | | |
| Hearing Aid Services<br>*Including exams and hearing aid accessories.*<br>*Limit: $5,000 every 24 months combined Network and Out-of-Network*<br>**Refer to SpecialOffers discounts in Additional Programs Solutions section for hearing aid discounts available.** | 20% | 40% |
| **Mental Health/Substance Abuse Care** | | |
| Hospital Inpatient Services | 20% | 40% |
| Outpatient Services | 20% | 40% |
| Physician Services | 20% | 40% |
| Applied Behavioral Analysis (ABA) Therapy<br>**Note: Coverage for the treatment of Mental Health and Substance Abuse Care conditions is provided in compliance with Federal law.** | 20% | 40% |
| **Nutritional Counseling for Diabetes** | 20% | 40% |
| **Nutritional Counseling (Non-Diabetic)**<br>*Limit: 6 visits per year combined Network and Out-of-Network*<br>*Covered for eating disorders with no visit limit.* | 20% | 40% |
| **Outpatient Hospital/Facility Services** | | |
| Outpatient Facility | 20% | 40% |
| Lab and X-Ray Services | 20% | 40% |
| Outpatient Physician Services (surgeon, anesthesiologist, radiologist, pathologist, etc.) | 20% | 40% |
| **Physician Services (Home and Office Visits)** | | |
| Primary Care Physician | 20% | 40% |
| Specialist Physician | 20% | 40% |



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | |
| Virtual Primary Care visits with Primary Care Providers through the Sydney Health mobile app with features such as a symptom checker, secure medical text chats, customized care plans, and referrals. | 20% | Not Applicable |
| Virtual Video Visits (LiveHealth Online) | 20% | Not Applicable |
| Telehealth<br>Consultations with Your Provider (PCP/Specialist) using visual and audio (Computer, Smart Phone, Tablet) | 20% | 40% |
| Telephonic<br>Consultations with Your Provider (PCP/Specialist) using audio only (telephone) | 20% | 40% |
| **COVID Benefits**<br>* NOTE: If the Provider bills You for an additional amount, please call Accolade Member Services at the number on the back of your Identification card for the claim to be reviewed to allow payment up to the Provider's billed charge. | | |
| Testing - through 5/11/2023 when the Public Health Emergency ends.<br>*Includes COVID Testing, Rapid Tests and Diagnosis based on Medical Necessity* | Covered at 100%, No Deductible | Covered at 100%, No Deductible* |
| *Testing received after 5/11/2023 will be covered* subject to the standard benefit provisions for both In-Network and Out-of-Network. | 20% | 40% |
| All other benefits related to COVID treatment are subject to the standard benefit provisions. | | |
| **Preventive Services**<br>**(Includes Virtual Primary Care Visits)** | **Covered at 100%, No Deductible** | 40% |
| **Skilled Nursing Facility** | 20% | 40% |
| **Limit Maximum days** | 120 days per Plan year combined Network and Out-of-Network. Combined Skilled Nursing Facility and Inpatient Medical Rehab. | |
| **Abortion (Therapeutic and Voluntary Termination of Pregnancy)** | 20% | 40% |



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | |
| **Gender Affirming Surgery** | 20% | 40% |
| **Bariatric Surgery**<br>Covered only when performed in a Blue Distinction Center facility. | 20% | Not Covered |
| For the Covered Bariatric Procedure, You will pay 20% when using a Blue Distinction Center + or Blue Distinction Center.<br><br>Members will be required to go to a Bariatric Blue Distinction Center for bariatric surgery if one is located within 50 miles of the Member's home. If a Bariatric Blue Distinction Center is available within 50 miles of the Member's home and the Member does not use one, the Member will pay the full cost of the surgery. Services must be obtained through a Bariatric Blue Distinction Center / Blue Distinction Center + if there is one located within 50 miles of Member's home. If there is not a Bariatric Blue Distinction Center / Blue Distinction Center + within 50 miles of Member's home, contact Accolade in advance of obtaining the Covered Service in order to get approval for a Network Provider (non-BDC+/BDC Facility) to be used.<br><br>**PAR Bariatric Surgery (non-BDC+/BDC Provider) and Out-of-Network Bariatric Provider:** There is NO benefit. | | |
| | | |
| **Blue Distinction Centers+/Blue Distinction Centers Transplant Surgery Benefit**<br><br>Members will be required to go to a Kidney Blue Distinction Center or Centers of Medical Excellence for Kidney Transplants if one is located within 50 miles of the Member's home. If a Kidney Blue Distinction Center or Centers of Medical Excellence is available within 50 miles of the Member's home and the Member does not use one, the Member will pay the full cost of the surgery. Services must be obtained through a Kidney Blue Distinction Center / Blue Distinction Center + if there is one located within 50 miles of Member's home. If there is not a Kidney Blue Distinction Center / Blue Distinction Center + within 50 miles of Member's home, contact Accolade in advance of obtaining the Covered Service in order to get approval for a Network Provider (non-BDC+/BDC Facility) to be used.<br><br>Services must be obtained through a Blue Distinction Center / Blue Distinction Center + for transplants if there is one located within 50 miles of Member's home. If there is not a Blue Distinction Center / Blue Distinction Center + within 50 miles of Member's home, contact Accolade in advance of obtaining the Covered Service in order to get approval for a Network Provider (non-BDC+/BDC Facility) to be used. | | |



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Benefits | | Member Responsibility | |
|---|---|---|---|
| | | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | | |
| | | | |
| **Designated BDC+ Provider for Transplant Surgery Procedures** | **Designated BDC Provider for Transplant Surgery procedures** | **PAR (Network) Transplant Provider (non-BDC+/BD Provider)** | **Non-PAR (Out-of-Network) Transplant Provider** |
| | | | |
| **Benefit Limits for Covered Transplant Procedure:** | | | |
| For the Covered **Transplant** Procedure, You will pay **20%** of the Maximum Allowed Amount when using a designated **BDC+** Provider. This benefit includes services directly related to the covered procedure (Facility, professional and ancillary services) during the Inpatient or outpatient stay. If the service is NOT directly related to the covered procedure, services will be covered based on Your standard medical benefit. | For the Covered **Transplant** Procedure, You will pay **20%** of the Maximum Allowed Amount when using a designated **BDC** Provider. This benefit includes services directly related to the covered procedure (Facility, professional and ancillary services) during the Inpatient or outpatient stay. If the service is NOT directly related to the covered procedure, services will be covered based on Your standard medical benefit. | Not Covered | Not Covered |
| | | | |
| **Deductibles** | | | |
| Deductibles apply | Deductibles apply | Not Covered | Not Covered |
| | | | |
| **Live Donor Searches** | | | |
| Covered at 20% subject to Deductible.<br><br>Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement. | Covered at 20% subject to Deductible.<br><br>Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement. | Not Covered | Not Covered |



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Benefits | | Member Responsibility | |
|---|---|---|---|
| | | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | | |
| | | | |
| **Bone Marrow Donor Search** | | | |
| Bone Marrow Donor Search fees are covered up to a maximum of $30,000 per transplant | Bone Marrow Donor Search fees up to a maximum of $30,000 per transplant | Not Covered | Not Covered |
| | | | |
| **Organ Transplants (institutional)** | | | |
| Donor expenses are covered at **20%** of Maximum Allowed Amount | Donor expenses are at **20%** of Maximum Allowed Amount | Not Covered | Not Covered |
| | | | |
| **Organ Transplants (professional)** | | | |
| Donor expenses are covered at **20%** of Maximum Allowed Amount | Donor expenses are at **20%** of Maximum Allowed Amount | Not Covered | Not Covered |
| | | | |
| **Organ Transplant Travel Reimbursement** | | | |
| Covered, as approved by the Claims Administrator, for applicable transportation and lodging expenses. Prior approval is required. Subject to a maximum of $10,000 per transplant. Must live 50 miles from transplant facility. | Covered, as approved by the Claims Administrator, for applicable transportation and lodging expenses. Prior approval is required. Subject to a maximum of $10,000 per transplant. Must live 50 miles from transplant facility. | Not Covered | Not Covered |

Contact Accolade Member Services for detailed information regarding organ transplant travel reimbursements. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Exclusions include:

- Meals - Restaurants & Take Out: Meals and snacks
- Food & beverage
- Valet parking
- Convenience items: telephone, fax
- Entertainment items: movies, books, and video rentals
- Furnishing for apartments: cooking utensils, appliances, furniture
- Groceries: Alcohol, cigarettes, paper products, toiletries; personal hygiene products
- Laundry service or dry cleaning
- Laundry detergent
- Gratuities of any kind



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | |
| • Moving trucks (e.g. U-Haul) | | |
| **Blue Distinction Orthopedic Surgery Benefit** | | |
| **Designated BDC+ Provider for Knee/Hip Replacements & Spine Surgery Procedures** | **Designated BDC Provider for Knee/Hip Replacements & Spine Surgery Procedures** | **PAR (Network) Orthopedic Provider (non-BDC+/BDC Provider)** | **Non-PAR (Out-of-Network) Orthopedic Provider** |
| **Benefit Limits for Covered Orthopedic Procedures:** | | |
| For the Covered Orthopedic Procedure, You will pay **0%** of the Maximum Allowed Amount when using a designated **BDC+** Provider. This benefit includes services directly related to the covered procedure (Facility, professional and ancillary services) during the Inpatient or outpatient stay. If the service is NOT directly related to the covered procedure, services will be covered based on Your standard medical benefit | For the Covered Orthopedic Procedure, You will pay **0%** of the Maximum Allowed Amount when using a designated **BDC** Provider. This benefit includes services directly related to the covered procedure (Facility, professional and ancillary services) during the Inpatient or outpatient stay. If the service is NOT directly related to the covered procedure, services will be covered based on Your standard medical benefit | For the Covered Orthopedic Procedure, You will pay **20%** of the Maximum Allowed Amount when using a **PAR** Network Provider. As the Provider is PAR (Network), You will NOT be responsible for amounts that exceed the Maximum Allowed Amount (You will NOT be required to pay any amounts due to Providers after Your health Plan benefits have been applied, beyond Your standard Out-of-Pocket costs). | For the Covered Orthopedic Procedure, You will pay **40%** of the Maximum Allowed Amount when using a **non-PAR** Out- of-Network Provider. As the Provider is non-PAR (Out-of-Network), You WILL be responsible for amounts that exceed the Maximum Allowed Amount (You WILL be required to pay any amounts due to Providers after Your health Plan benefits have been applied). |
| | | | |
| **Deductibles:** | | | |
| Network Deductibles apply | Network Deductibles apply | Network Deductibles apply | Out-of-Network Deductibles will apply. |
| | | | |
| **Therapy Services (Outpatient)** | | | |
| Physical Therapy* | | 20% | 40% |
| Occupational Therapy* | | 20% | 40% |



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | |
| Speech Therapy* | 20% | 40% |
| Cardiac Rehabilitation | 20% | 40% |
| Manipulation Therapy<br>*Limit: 24 visits per year (Combined Network and Out-of-Network)* | 20% | 40% |
| Radiation Therapy | 20% | 40% |
| Chemotherapy | 20% | 40% |
| Respiratory Therapy | 20% | 40% |
| Vision Therapy | 20% | 40% |
| ***Combined Limit –** Benefits for Physical Therapy, Occupational Therapy, Speech Therapy, are limited to 60 visits per Plan year, combined Network and Out-of-Network. Additional visits may be approved based on Medical Necessity.<br>Autism Diagnosis are not included in the visit limit. | | |
| **Travel Reimbursement**<br>**(All Services excluding Organ Transplants)** | Covered at 100%, After Deductible | Not Covered |
| Travel reimbursement rules for organ transplants are provided above under "Organ Transplant Travel Reimbursement". This section applies to travel reimbursements for all other Covered Services. Unless as prohibited by law, the Claims Administrator will cover reasonable and necessary travel costs when You are required to travel to another state to obtain Covered Services that are not available within Your state of residence.<br><br>Travel and Lodging Expenses may be available for services received at a Network provider. Accolade will assist the patient and family with travel and lodging reimbursement when the Member is unable to locate a Network or Out of Network provider within their state of residence. Eligibility can be confirmed with Accolade per the rules listed in this document. Expenses for travel and lodging for the recipient and a companion should be verified by working with Accolade to obtain the specific travel reimbursement claim form. Travel Reimbursement may be available as follows:<br>• Transportation is covered, including expenses for personal car mileage at the current Federal rate of reimbursement, of the patient and one companion who is traveling on the same day(s) to and/or from the site of the surgery for an evaluation, the procedure, or necessary post-discharge follow-up;<br>• Reasonable and necessary expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per-diem rate of $50 for one person or $100 a day for two people (a maximum of $50 per person — $100 for patient and companion combined — per night is paid toward lodging expenses. To qualify for the $100 per day, the companion must be serving as a caregiver to the patient; meals are not covered; | | |



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | |

- Travel and lodging expenses are available only for Network Medical services that are not available in the covered member's state of residence from any provider (Network or Out of Network).
- If the patient is a covered Dependent minor child, the travel expenses of two companions will be covered; lodging expenses will be reimbursed at the $100 per-diem rate.
- These benefits are subject to a maximum of $1,000 per member and adult companion(s), per occurrence, for all covered transportation and lodging expenses incurred by the Member receiving the service and companion (two primary guardians, if the covered Dependent is a minor), and reimbursed under the Plan. No annual or lifetime limits.
- For information about the transportation and lodging benefits, please contact Accolade Member Services at 1-833-640-0427.

The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Claims Administrator when the qualifying Medical claim is on file. Contact Accolade Member Services for detailed information. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Exclusions include:

- Meals - Restaurants & Take Out: Meals and snacks
- Food & beverage
- Valet parking
- Convenience items: telephone, fax
- Entertainment items: movies, books, and video rentals
- Furnishing for apartments: cooking utensils, appliances, furniture
- Groceries: Alcohol, cigarettes, paper products, toiletries; personal hygiene products
- Laundry service or dry cleaning
- Laundry detergent
- Gratuities of any kind
- Moving trucks (e.g. U-Haul)



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

# Higher Deductible HSA Plan

If You are enrolled in the Higher Deductible HSA Plan, the following schedule of benefits shall apply.

| Schedule of Benefits | Network | Out-of-Network[1] |
|---|---|---|
| **Calendar Year Deductible** | | |
| **Individual** | $2,200 | $4,400 |
| **Family[3]** | $4,400 | $8,800 |
| Charges in excess of the Maximum Allowed Amount do not contribute to the Deductible. | | |
| **All Covered Services are subject to the Deductible unless otherwise specified in this booklet.** | | |
| **Family applies to the Employee + Child(ren), Employee + Spouse/Qualified Domestic Partner and Employee + Family levels of coverage.**<br><br>**[3]The Plan has a True Family Deductible.** Under a true family deductible, if only one family member becomes ill or injured, that person must meet the family deductible (rather than the individual deductible) before the Plan pays for benefits. In this case, the Plan requires satisfaction of the family deductible before any coinsurance will be paid. | | |
| The Network and Out-of-Network **Calendar** year Deductibles are separate and cannot be combined. | | |
| **Coinsurance After the Calendar Year Deductible is Met (Unless Otherwise Specified)**<br><br>Contact Accolade at 1-833-640-0427 if you have questions about how the Plan pays. | | |
| **Plan Pays** | 80% | 60% |
| **Member Pays** | 20% | 40% |
| All payments are based on the Maximum Allowed Amount and any negotiated arrangements. Except for Surprise Billing Claims, if You use an Out-of-Network Provider, may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount, also known as "balance billing". Depending on the service, this difference can be substantial. | | |
| **Out-of-Pocket Maximum Per Calendar Year**<br><br>Includes Coinsurance and the **Calendar** year Deductible. Does NOT include charges in excess of the Maximum Allowed Amount or Non-Covered Services.<br><br>The Network and Out-of-Network Out-of-Pocket Maximums are separate and cannot be combined. Once one individual or a combination of family members meet the applicable annual family Out-of-Pocket Maximum, the Plan pays 100% of eligible medical expenses for all family members for such Network or Out-of-Network Services, as the case may be depending on which Out-of-Pocket Maximum has been met. | | |



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Base Pay Range | Network Out-of-Pocket Maximum | Out-of-Network Out-of-Pocket Maximum |
|---|---|---|
| **$0 - $29,999** | | |
| **Individual** | $2,800 | $5,600 |
| **Family** | $5,600 | $11,200 |
| **$30,000 - $49,999** | | |
| **Individual** | $4,000 | $8,000 |
| **Family[2]** | $8,000 | $16,000 |
| **$50,000 - $79,999** | | |
| **Individual** | $5,000 | $10,000 |
| **Family[2]** | $10,000 | $20,000 |
| **$80,000 - $124,999** | | |
| **Individual** | $6,000 | $12,000 |
| **Family[2]** | $12,000 | $24,000 |
| **$125,000+** | | |
| **Individual** | $6,650 | $13,300 |
| **Family[2]** | $13,300 | $26,600 |

[2]Out-of-Pocket expenses paid for an individual with family coverage are limited to no more than $7,900 for Network coverage before the Plan pays 100 percent of eligible medical expenses.



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | |
| **Acupuncture**<br>20 Visits Per calendar year combined Network and Out-of-Network | 20% | 40% |
| **Allergy Care** | | |
| Testing – Physician or Specialist Physician | 20% | 40% |
| Treatment – Physician or Specialist Physician | 20% | 40% |
| **Ambulance Services** | | |
| Ambulance Services (when Medically Necessary)<br>Air | 20% | 20% |
| Ambulance Services (when Medically Necessary)<br>Ground | 20% | 20% |
| **Note:** If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges. | | |
| **Clinical Trials**<br>Please refer to Clinical Trials in the **Benefits** section for further information.<br>*If a member is part of an FDA-approved clinical trial for a life-threatening disease, medical expenses that are currently covered under the plan that happen during that trial will be covered.* | 20% | 40% |
| **Dental & Oral Surgery/TMJ Services**<br>Dental<br>*Covered for treatment of an injury to sound and natural teeth.*<br>. | 20% | 40% |
| Oral Surgery<br>*Includes removal of impacted teeth. Dental Anesthesia is covered only if related to a payable oral surgery.* | 20% | 40% |
| TMJ Treatment | Not Covered | Not Covered |
| **Diagnostic Physician's Services** | | |
| Diagnostic services (including second opinion) by a Physician or Specialist Physician – office visit or home visit: | | |
| Primary Care Physician | 20% | 40% |
| Specialist Physician | 20% | 40% |



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | |
| Diagnostic X-ray and Lab – office or independent lab (Routine) | Covered at 100%, No Deductible | 40% |
| Diagnostic X-ray and Lab – office or independent lab (Non-Routine) | 20% | 40% |
| High Diagnostic Imaging (including MRIs, CAT scans) | 20% | 40% |
| **Note: Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.** | | |
| **Emergency Room and Urgent Care** | | |
| Emergency Room<br>*Prudent Layperson guidelines apply.* | 20% | 20% |
| Urgent Care | 20% | 40% |

**Note: Care received Out-of-Network for an Emergency Medical Condition will be provided at the Network level of benefits if the following conditions apply:** A medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:
(1) Placing the health of the individual or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
(2) Serious impairment to bodily functions; or
(3) Serious dysfunction of any bodily organ or part.

If an Out-of-Network Provider is used for Emergency services, claims will be covered at the Network benefit level, however, You may be billed the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges, unless Your claim is a Surprise Billing Claim. If the Provider bills You for this additional amount, please call Accolade Member Services at the number on the back of your Member Identification Card for the claim to be reviewed.

As described in the **Consolidated Appropriations Act of 2021 Notice** in the **Health Benefits Coverage Under Federal Law** section, Out-of-Network Providers may only bill You for any applicable Deductible and Coinsurance and may not bill You for any charges over the Plan's Maximum Allowed Amount until the treating Out-of-Network Provider has determined You are stable. . Please refer to the Notice in the **Health Benefits Coverage Under Federal Law** section for more details.

**Explanation of Benefits (EOB) Message:** EOB will confirm this claim has been processed at the Network benefit level. If the Provider bills You for an additional amount, please call Accolade Member Services at the number on the back of your Member Identification Card for the claim to be reviewed to allow payment up to the Provider's billed charges. You will need to provide a copy of the Explanation of Benefits and the Provider's bill as part of the review. Make sure Your Member Identification number is on the bill.



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | |
| **Eye Care - Non-Routine** | | |
| Office Visit – medical eye care exams (treatment of disease or Injury to the eye) | | |
| Primary Care Physician | 20% | 40% |
| Specialist Physician | 20% | 40% |
| Treatment other than office visit | 20% | 40% |
| Routine eye exams are not a Covered Service. | | |
| **Gene Therapy Services**<br>• Precertification required | 20% | 40% |
| **Hearing Care - Non-Routine** | | |
| Office Visit – Audiometric exam/hearing evaluation test | | |
| Primary Care Physician | 20% | 40% |
| Specialist Physician | 20% | 40% |
| Hearing Devices/Hearing Aids<br>*Including exams and hearing aid accessories.*<br>*Limit $5,000 Every 24 Months*<br>**Refer to SpecialOffers discounts in Additional Programs Solutions section for hearing aid discounts available.** | 20% | 40% |
| Routine hearing exams are not a Covered Service. | | |
| **Home Health Care Services**<br>*60 visits per calendar year combined Network and Out-of-Network.*<br>*The limit is combined with Private Duty Nursing* | 20% | 40% |
| **Private Duty Nursing**<br>*60 visits per calendar year combined Network and Out-of-Network.*<br>*The limit is combined with Home Health Care Services* | 20% | 40% |
| **Hospice Care Services** | 20% | 40% |
| Except for Surprise Billing Claims, Out-of-Network Providers may also bill You for any charges over the Plan's Maximum Allowed Amount. | | |



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | |
| **Hospital Inpatient Services – Precertification Required** | | |
| Room and Board (Semiprivate or ICU/CCU) | 20% | 40% |
| Hospital Services and Supplies<br>• Inpatient Physical Medical Rehab<br>*120 days per Plan year combined Network and Out-of-Network. Combined Skilled Nursing Facility and Inpatient Medical Rehab.* | 20% | 40% |
| Pre-Admission Testing | 20% | 40% |
| Physician Services*: | | |
| ► Assistant Surgeon | 20% | 40% |
| ► Anesthesiologist | 20% | 40% |
| ► Radiologist | 20% | 40% |
| ► Pathologist | 20% | 40% |
| **Note:** *Assistant surgeon, anesthesiologist, radiologist, pathologist and emergency room physician services rendered by Out-of-Network Providers in a Network hospital setting are covered at the Network level of benefits; however, You may be billed the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges, unless Your claim is a Surprise Billing Claim. If the Provider bills You for this additional amount, please call Accolade Member Services at the number on the back of your Member Identification Card for the claim to be reviewed.<br><br>**Explanation of Benefits (EOB) Message:** EOB will confirm this claim has been processed at the Network benefit level. If the Provider bills You for an additional amount, please call Accolade Member Services at the number on the back of your Member Identification Card for the claim to be reviewed to allow payment up to the Provider's billed charges. You will need to provide a copy of the Explanation of Benefits and the Provider's bill as part of the review. Make sure Your Member Identification number is on the bill. | | |
| **Maternity Care** | | |
| Inpatient | 20% | 40% |
| Lactation Consultations | First 6 visits:<br>Covered at 100%<br>Additional visits: 20% | 40% |



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | |
| Global Maternity Charges Office Professional Visit<br>*Network: 1st 40% of Global maternity charges covered at 100%, remaining 60% is covered subject to Deductible and Coinsurance.*<br>*Out-of-Network: maternity charges covered at Out-of-Network Deductible and Coinsurance.*<br>**Note:** Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48 hours for a vaginal delivery or 96 hours for a cesarean section, must be pre-certified. | 20% | 40% |
| **Fertility Services**<br>*Treatment covered only when performed in a Blue Distinction Center/Blue Distinction Center+ Facility.* | | |
| Diagnostic Services | 20% | 40% |
| Fertility Services have a combined Medical and Pharmacy Lifetime Maximum | $50,000 Per Lifetime | Network Only |
| Treatment | 20% | Not Covered |
| Elective egg/sperm cryopreservation coverage – 1 year of storage<br>*Services must be obtained through a Blue Distinction Center/Blue Distinction Center + if there is one located within 50 miles of Member's home. If there is not a Blue Distinction Center/Blue Distinction Center + within 50 miles of Member's home, contact Accolade in advance of obtaining the Covered Service in order to get approval for a Network Provider (non-BDC+/BDC Facility) to be used.*<br>*Covered Services include but are not limited to: in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination.* | | |
| **Sterilization Services (Precertification required for Inpatient procedures)** | 20% | 40% |
| Sterilizations for women will be covered under the "Preventive Services" benefit. Please refer to that section in **Benefits** for further details. | | |
| **Medical Supplies and Equipment** | | |
| Medical Supplies | 20% | 40% |
| Durable Medical Equipment | 20% | 40% |



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| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | |
| Orthotics<br>*Wigs/Toupees limited to 1 per year, subject to Medical Necessity.*<br>*Includes Foot Orthotics based on Medical Necessity.* | 20% | 40% |
| Hearing Aid Services<br>*Including exams and hearing aid accessories.*<br>*Limit: $5,000 every 24 months combined Network and Out-of-Network*<br>**Refer to SpecialOffers discounts in Additional Programs Solutions section for hearing aid discounts available.** | 20% | 40% |
| **Mental Health/Substance Abuse Care** | | |
| Hospital Inpatient Services | 20% | 40% |
| Outpatient Services | 20% | 40% |
| Physician Services | 20% | 40% |
| Applied Behavioral Analysis (ABA) Therapy<br>**Note: Coverage for the treatment of Mental Health and Substance Abuse Care conditions is provided in compliance with Federal law.** | 20% | 40% |
| **Nutritional Counseling for Diabetes** | 20% | 40% |
| **Nutritional Counseling (Non-Diabetic)**<br>*Limit: 6 visits per year combined Network and Out-of-Network*<br>*Covered for eating disorders with no visit limit.* | 20% | 40% |
| **Outpatient Hospital/Facility Services** | | |
| Outpatient Facility | 20% | 40% |
| Lab and X-Ray Services | 20% | 40% |
| Outpatient Physician Services (surgeon, anesthesiologist, radiologist, pathologist, etc.) | 20% | 40% |
| **Physician Services (Home and Office Visits)** | | |
| Primary Care Physician | 20% | 40% |
| Specialist Physician | 20% | 40% |



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| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | |
| Virtual Primary Care visits with Primary Care Providers through the Sydney Health mobile app with features such as a symptom checker, secure medical text chats, customized care plans, and referrals. | 20% | Not Applicable |
| Virtual Video Visits (LiveHealth Online) | 20% | Not Applicable |
| Telehealth<br>Consultations with Your Provider (PCP/Specialist) using visual and audio (Computer, Smart Phone, Tablet) | 20% | 40% |
| Telephonic<br>Consultations with Your Provider (PCP/Specialist) using audio only (telephone) | 20% | 40% |
| **COVID Benefits**<br>* NOTE: If the Provider bills You for an additional amount, please call Accolade Member Services at the number on the back of your Identification card for the claim to be reviewed to allow payment up to the Provider's billed charge. | | |
| Testing - through 5/11/2023 when the Public Health Emergency ends.<br>*Includes COVID Testing, Rapid Tests and Diagnosis based on Medical Necessity.* | Covered at 100%, No Deductible | Covered at 100%, No Deductible* |
| *Testing received after 5/11/2023 will be covered* subject to the standard benefit provisions for both In-Network and Out-of-Network. | 20% | 40% |
| All other benefits related to COVID treatment are subject to the standard benefit provisions. | | |
| **Preventive Services**<br>**(Includes Virtual Primary Care Visits)** | **Covered at 100%, No Deductible** | 40% |
| **Skilled Nursing Facility** | 20% | 40% |
| **Limit Maximum days** | 120 days per Plan year combined Network and Out-of-Network. Combined Skilled Nursing Facility and Inpatient Medical Rehab. | |
| **Abortion (Therapeutic and Voluntary Termination of Pregnancy)** | 20% | 40% |



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| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | |
| **Gender Affirming Surgery** | 20% | 40% |
| **Bariatric Surgery**<br>Covered only when performed in a Blue Distinction Center facility. | 20% | Not Covered |
| For the Covered Bariatric Procedure, You will pay 20% when using a Blue Distinction Center + or Blue Distinction Center.<br><br>Members will be required to go to a Bariatric Blue Distinction Center for bariatric surgery if one is located within 50 miles of the Member's home. If a Bariatric Blue Distinction Center is available within 50 miles of the Member's home and the Member does not use one, the Member will pay the full cost of the surgery. Services must be obtained through a Bariatric Blue Distinction Center / Blue Distinction Center + if there is one located within 50 miles of Member's home. If there is not a Bariatric Blue Distinction Center / Blue Distinction Center + within 50 miles of Member's home, contact Accolade in advance of obtaining the Covered Service in order to get approval for a Network Provider (non-BDC+/BDC Facility) to be used.<br><br>**PAR Bariatric Surgery (non-BDC+/BDC Provider) and Out-of-Network Bariatric Provider:** There is NO benefit. | | |
| | | |
| **Blue Distinction Centers+/Blue Distinction Centers Transplant Surgery Benefit**<br><br>Members will be required to go to a Kidney Blue Distinction Center or Centers of Medical Excellence for Kidney Transplants if one is located within 50 miles of the Member's home. If a Kidney Blue Distinction Center or Centers of Medical Excellence is available within 50 miles of the Member's home and the Member does not use one, the Member will pay the full cost of the surgery. Services must be obtained through a Kidney Blue Distinction Center / Blue Distinction Center + if there is one located within 50 miles of Member's home. If there is not a Kidney Blue Distinction Center / Blue Distinction Center + within 50 miles of Member's home, contact Accolade in advance of obtaining the Covered Service in order to get approval for a Network Provider (non-BDC+/BDC Facility) to be used.<br><br>Services must be obtained through a Blue Distinction Center / Blue Distinction Center + for transplants if there is one located within 50 miles of Member's home. If there is not a Blue Distinction Center / Blue Distinction Center + within 50 miles of Member's home, contact Accolade in advance of obtaining the Covered Service in order to get approval for a Network Provider (non-BDC+/BDC Facility) to be used. | | |



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| Benefits | | Member Responsibility | |
|---|---|---|---|
| | | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | | |
| | | | |
| **Designated BDC+ Provider for Transplant Surgery Procedures** | **Designated BDC Provider for Transplant Surgery procedures** | **PAR (Network) Transplant Provider (non-BDC+/BD Provider)** | **Non-PAR (Out-of-Network) Transplant Provider** |
| | | | |
| **Benefit Limits for Covered Transplant Procedure:** | | | |
| For the Covered **Transplant** Procedure, You will pay **20%** of the Maximum Allowed Amount when using a designated **BDC+** Provider. This benefit includes services directly related to the covered procedure (Facility, professional and ancillary services) during the Inpatient or outpatient stay. If the service is NOT directly related to the covered procedure, services will be covered based on Your standard medical benefit. | For the Covered **Transplant** Procedure, You will pay **20%** of the Maximum Allowed Amount when using a designated **BDC** Provider. This benefit includes services directly related to the covered procedure (Facility, professional and ancillary services) during the Inpatient or outpatient stay. If the service is NOT directly related to the covered procedure, services will be covered based on Your standard medical benefit. | Not Covered | Not Covered |
| | | | |
| **Deductibles** | | | |
| Deductibles apply | Deductibles apply | Not Covered | Not Covered |
| | | | |
| **Live Donor Searches** | | | |
| Covered at 20% subject to Deductible.<br><br>Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement. | Covered at 20% subject to Deductible.<br><br>Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement. | Not Covered | Not Covered |



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Benefits | | Member Responsibility | |
|---|---|---|---|
| | | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | | |
| | | | |
| **Bone Marrow Donor Search** | | | |
| Bone Marrow Donor Search fees are covered up to a maximum of $30,000 per transplant | Bone Marrow Donor Search fees up to a maximum of $30,000 per transplant | Not Covered | Not Covered |
| | | | |
| **Organ Transplants (institutional)** | | | |
| Donor expenses are covered at **20%** of Maximum Allowed Amount | Donor expenses are at **20%** of Maximum Allowed Amount | Not Covered | Not Covered |
| | | | |
| **Organ Transplants (professional)** | | | |
| Donor expenses are covered at **20%** of Maximum Allowed Amount | Donor expenses are at **20%** of Maximum Allowed Amount | Not Covered | Not Covered |
| | | | |
| **Organ Transplant Travel Reimbursement** | | | |
| Covered, as approved by the Claims Administrator, for applicable transportation and lodging expenses. Prior approval is required. Subject to a maximum of $10,000 per transplant. Must live 50 miles from transplant facility. | Covered, as approved by the Claims Administrator, for applicable transportation and lodging expenses. Prior approval is required. Subject to a maximum of $10,000 per transplant. Must live 50 miles from transplant facility. | Not Covered | Not Covered |

Contact Accolade Member Services for detailed information regarding organ transplant travel reimbursements. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Exclusions include:

- Meals - Restaurants & Take Out: Meals and snacks
- Food & beverage
- Valet parking
- Convenience items: telephone, fax
- Entertainment items: movies, books, and video rentals
- Furnishing for apartments: cooking utensils, appliances, furniture
- Groceries: Alcohol, cigarettes, paper products, toiletries; personal hygiene products
- Laundry service or dry cleaning
- Laundry detergent
- Gratuities of any kind



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| Benefits | | | Member Responsibility | |
|---|---|---|---|---|
| | | | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | | | |
| • Moving trucks (e.g. U-Haul) | | | | |
| **Blue Distinction Orthopedic Surgery Benefit** | | | | |
| **Designated BDC+ Provider for Knee/Hip Replacements & Spine Surgery Procedures** | **Designated BDC Provider for Knee/Hip Replacements & Spine Surgery Procedures** | **PAR (Network) Orthopedic Provider (non-BDC+/BDC Provider)** | **Non-PAR (Out-of-Network) Orthopedic Provider** | |
| **Benefit Limits for Covered Orthopedic Procedures:** | | | | |
| For the Covered Orthopedic Procedure, You will pay **0%** of the Maximum Allowed Amount when using a designated **BDC+** Provider. This benefit includes services directly related to the covered procedure (Facility, professional and ancillary services) during the Inpatient or outpatient stay. If the service is NOT directly related to the covered procedure, services will be covered based on Your standard medical benefit | For the Covered Orthopedic Procedure, You will pay **0%** of the Maximum Allowed Amount when using a designated **BDC** Provider. This benefit includes services directly related to the covered procedure (Facility, professional and ancillary services) during the Inpatient or outpatient stay. If the service is NOT directly related to the covered procedure, services will be covered based on Your standard medical benefit | For the Covered Orthopedic Procedure, You will pay **20%** of the Maximum Allowed Amount when using a **PAR** Network Provider. As the Provider is PAR (Network), You will NOT be responsible for amounts that exceed the Maximum Allowed Amount (You will NOT be required to pay any amounts due to Providers after Your health Plan benefits have been applied, beyond Your standard Out-of-Pocket costs). | For the Covered Orthopedic Procedure, You will pay **40%** of the Maximum Allowed Amount when using a **non-PAR** Out- of-Network Provider. As the Provider is non-PAR (Out-of-Network), You WILL be responsible for amounts that exceed the Maximum Allowed Amount (You WILL be required to pay any amounts due to Providers after Your health Plan benefits have been applied). | |
| | | | | |
| **Deductibles:** | | | | |
| Network Deductibles apply | Network Deductibles apply | Network Deductibles apply | Out-of-Network Deductibles will apply. | |
| | | | | |
| **Therapy Services (Outpatient)** | | | | |
| Physical Therapy* | | | 20% | 40% |
| Occupational Therapy* | | | 20% | 40% |



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | |
| Speech Therapy* | 20% | 40% |
| Cardiac Rehabilitation | 20% | 40% |
| Manipulation Therapy<br>*Limit: 24 visits per year (Combined Network and Out-of-Network)* | 20% | 40% |
| Radiation Therapy | 20% | 40% |
| Chemotherapy | 20% | 40% |
| Respiratory Therapy | 20% | 40% |
| Vision Therapy | 20% | 40% |
| ***Combined Limit –** Benefits for Physical Therapy, Occupational Therapy, Speech Therapy, are limited to 60 visits per Plan year, combined Network and Out-of-Network. Additional visits may be approved based on Medical Necessity.<br>Autism Diagnosis are not included in the visit limit. | | |
| **Travel Reimbursement (All Services excluding Organ Transplants)** | Covered at 100%, After Deductible | Not Covered |
| Travel reimbursement rules for organ transplants are provided above under "Organ Transplant Travel Reimbursement". This section applies to travel reimbursements for all other Covered Services. Unless as prohibited by law, the Claims Administrator will cover reasonable and necessary travel costs when You are required to travel to another state to obtain Covered Services that are not available within Your state of residence.<br><br>Travel and Lodging Expenses may be available for services received at a Network provider. Accolade will assist the patient and family with travel and lodging reimbursement when the Member is unable to locate a Network or Out of Network provider within their state of residence. Eligibility can be confirmed with Accolade per the rules listed in this document. Expenses for travel and lodging for the recipient and a companion should be verified by working with Accolade to obtain the specific travel reimbursement claim form. Travel Reimbursement may be available as follows:<br>• Transportation is covered, including expenses for personal car mileage at the current Federal rate of reimbursement, of the patient and one companion who is traveling on the same day(s) to and/or from the site of the surgery for an evaluation, the procedure, or necessary post-discharge follow-up;<br>• Reasonable and necessary expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per-diem rate of $50 for one person or $100 a day for two people (a maximum of $50 per person — $100 for patient and companion combined — per night is paid toward lodging expenses. To qualify for the $100 per day, the companion must be serving as a caregiver to the patient; meals are not covered; | | |



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

| Benefits | Member Responsibility | |
|---|---|---|
| | Network | Out-of-Network[1] |
| **Note: All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this Benefit Booklet** | | |
| • Travel and lodging expenses are available only for Network Medical services that are not available in the covered member's state of residence from any provider (Network or Out of Network).<br>• If the patient is a covered Dependent minor child, the travel expenses of two companions will be covered; lodging expenses will be reimbursed at the $100 per-diem rate.<br>• These benefits are subject to a maximum of $1,000 per member and adult companion(s), per occurrence, for all covered transportation and lodging expenses incurred by the Member receiving the service and companion (two primary guardians, if the covered Dependent is a minor), and reimbursed under the Plan. No annual or lifetime limits.<br>• For information about the transportation and lodging benefits, please contact Accolade Member Services at 1-833-640-0427.<br>The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Claims Administrator when the qualifying Medical claim is on file. Contact Accolade Member Services for detailed information. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.<br>Exclusions include:<br>• Meals - Restaurants & Take Out: Meals and snacks<br>• Food & beverage<br>• Valet parking<br>• Convenience items: telephone, fax<br>• Entertainment items: movies, books, and video rentals<br>• Furnishing for apartments: cooking utensils, appliances, furniture<br>• Groceries: Alcohol, cigarettes, paper products, toiletries; personal hygiene products<br>• Laundry service or dry cleaning<br>• Laundry detergent<br>• Gratuities of any kind<br>• Moving trucks (e.g. U-Haul) | | |



[1] Except for Surprise Billing Claims, when You use an Out-of-Network Provider, You may be billed for any balance due between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any Coinsurance, Deductibles and non-covered charges.

**PLEASE NOTE: THE REMAINDER OF THIS DOCUMENT APPLIES TO ALL MEMBERS ENROLLED IN THE COPAY PLAN, LOWER DEDUCTIBLE HSA PLAN AND THE HIGHER DEDUCTIBLE HSA PLAN.**

# ADDITIONAL PROGRAM SOLUTIONS

## Sydney Mobile App

On the go, we're with You. Find an urgent care center. Share Your Identification Card on Your smartphone at the doctor's office. Check Your claim status. With the Anthem Sydney Mobile app, You can find a doctor, access Your mobile Health Record, view Your Identification Card, check Your claim status, and more – all from Your smartphone or mobile device.

## Autism Spectrum Disorders (ASD) Program

The ASD Program is comprised of a specialized, dedicated team of clinicians within Anthem who have been trained on the unique challenges and needs of families with a Member who has a diagnosis of ASD. The Program includes Precertification and Medical Necessity reviews for Applied Behavior Analysis, a treatment modality targeting the symptoms of autism spectrum disorders.

## Quick Care Options

Quick Care Options helps to raise Your awareness about appropriate alternatives to Hospital emergency rooms (ERs). When You need care right away, Retail Health Clinics and Urgent Care centers can offer appropriate care for less cost and leave the ER available for actual emergencies. Quick Care Options educates You on the availability of ER alternatives for non-urgent diagnoses and provides the Provider finder website to support searches for ER alternatives.

## SpecialOffers discounts

Save money with discounts at anthem.com

As an Anthem Member, You qualify for discounts on products and services that help promote better health and well-being.* These discounts are available through Special Offers for Anthem members to help You save money while taking care of Your health.

You may have opportunities to save money on products, resources, and services like hearing aids, glasses, and a variety of other tools and wellness programs. To find the discounts available to You, follow these simple steps:

1. Log in to www.anthem.com,
2. Choose "Care"
3. Select "Discounts"

*Note: All discounts are subject to change without notice.

## Virtual Primary Care

Through Anthem's website, www.anthem.com and Anthem's Sydney Health mobile application, Anthem Members have access to convenient, affordable on-demand and scheduled secure medical text-chat and video visits for Urgent Care and primary care spanning Urgent Care, prevention and wellness, and condition management for adults ages 18-64. Anthem's virtual care experience also provides Members with care guidance through a variety of tools such as the AI-driven symptom checker for assessing their symptoms prior to receiving virtual medical care.

Our virtual primary care service offers Members:

- comprehensive primary care, coordinated by a care team;
- 24/7, on-demand Urgent Care support;
- full preventive care wellness exam;
- chronic condition visits;

personalized care plans and follow-ups; and

- unlimited access to care, including Prescription refills and referrals.

# ELIGIBILITY

Please refer to The Bank of New York Mellon Health and Welfare Plan and Summary Plan Description (as may be amended from time to time), which can be obtained from the Plan Administrator, for the Plan's eligibility requirements. You can also access it through the MyBenefit Solutions website:

- **At Work:** Single sign-on access through People Rewards (MySource > People > People Rewards > My External Links > Health > MyBenefit Solutions > Plan Documents > Health and Welfare Summary Plan Description)
- **At Home:** Visit MyBenefit Solutions at mybenefits.bnymellon.com. (If you're a new employee or haven't already registered, you'll need to create a username and password.)

Additional information is also available on MySource at People > Benefits > 2023 Benefits Guide.

## Coverage for the Employee

This Benefit Booklet describes the benefits applicable to an Employee enrolled in the Copay Plan, the Lower Deductible HSA Plan and the Higher Deductible HSA Plan. The Employee is also called a Subscriber.

## Coverage for the Employee's Dependents

If the Employee is covered by the Copay Plan, the Lower Deductible HSA Plan or the Higher Deductible HSA Plan, the Employee may also enroll their eligible Dependents. Covered Dependents are also called Members.

# HOW THE PLAN WORKS

Note: Capitalized terms such as Covered Services, Medical Necessity, and Out-of-Pocket Maximum are defined in the **Definitions** Section.

## Introduction

**The Plan is a Preferred Provider Organization (PPO) for all Members except residents of DC/Maryland/Northern Virginia, Florida, New Jersey and New Hampshire; Members residing in those states are part of a Point of Service (POS) Plan, and must use the appropriate POS Network Provider in their respective states to receive Network benefits.** If you are a resident of DC/Maryland/Northern Virginia, Florida, New Jersey or New Hampshire and are receiving care outside of your respective state of residence, you will utilize the BlueCard PPO Network. If You are a Member residing in a state outside of DC/Maryland/Northern Virginia, Florida, New Jersey and New Hampshire and are receiving care outside of your respective state of residence, you will utilize the National BlueCard PPO network. For assistance in locating a Network provider, contact the Accolade Member Services number on the back of Your Member Identification Card. The PPO and POS Plans are divided into two sets of benefits: Network and Out-of-Network. If You choose a Network Provider, You will receive Network benefits. Utilizing this method means You will not have to pay as much money; Your Out-of-Pocket expenses will be higher when You use Out-of-Network Providers.

Providers are compensated using a variety of payment arrangements, including fee for service, per diem, discounted fees, and global reimbursement.

All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied.

## Network Services

When You use a Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. The Plan has the final authority to decide the Medical Necessity of the service.

If You receive Covered Services from an Out-of-Network Provider after we failed to provide You with accurate information in our Provider directory at www.anthem.com, or after we failed to respond to Your telephone or web-based inquiry within the time required by Federal law, Covered Services will be covered at the Network level.

If Your Network Provider leaves our network for any reason other than termination by Anthem for cause and You are in active treatment, You may be able to continue seeing that Provider for a limited period of time and still get Network benefits. “Active treatment” includes:

1) An ongoing course of treatment for a life-threatening condition,
2) An ongoing course of treatment for a serious acute condition (e.g., chemotherapy, radiation therapy and post-operative visits),
3) The second or third trimester of pregnancy and through the postpartum period, or
4) An ongoing course of treatment for a health condition for which the Physician or health care Provider attests that discontinuing care by the current Physician or Provider would worsen Your condition or interfere with anticipated outcomes.

An “ongoing course of treatment” includes treatments for mental health and substance use disorders.

In these cases, You may be able to continue seeing that Provider until treatment is complete, or for 90 days, whichever is shorter. If You wish to continue seeing the same Provider, You should contact Member Services for details. Any decision by the Plan regarding a request for Continuity of Care is subject to review.

**Network Providers** include Primary Care Physicians/Providers (PCPs), Specialists (Specialty Physicians/Providers – SCPs), other professional Providers, Hospitals, and other Facilities who contract with us to care for You. Referrals are never needed to visit a Network Specialist, including mental health Providers.

To see a Physician, call their office:

- Tell them You are an Anthem Member.
- Have Your Member Identification Card handy. The Physician's office may ask You for Your group or Member ID number.
- Tell them the reason for Your visit.

When You go to the office, be sure to bring Your Member Identification Card with You.

For services from Network Providers:

1. You will not need to file claims. Network Providers will file claims for Covered Services for You. (You will still need to pay any Coinsurance, Copayments, and/ Deductibles that apply.) You may be billed by Your Network Provider(s) for any Non-Covered Services You get or when You have not followed the terms of this Benefit Booklet.
2. Precertification will be done by the Network Provider. (Please refer to the Healthcare Management – Precertification section for further details.)

Please refer to the Claims Payment section for additional information on Authorized Services.

## After Hours Care

If You need care after normal business hours, Your Physician may have several options for You. You should call Your Physician's office for instructions if You need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If You have an Emergency, call 911 or go to the nearest Emergency Room.

## Out-of-Network Services

When You do not use a Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Benefit Booklet.

For services from an Out-of-Network Provider:

- There is no limit to what an Out-of-Network Provider can charge unless Your claim involves a Surprise Billing Claim;
- The Out-of-Network Provider can charge You the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments; unless Your claim involves a Surprise Billing Claim;
- You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments); unless Your claim involves a Surprise Billing Claim;
- You will have to pay for services that are not Medically Necessary;
- You will have to pay for Non-Covered Services;
- You may have to file claims; and
- You must make sure any necessary Precertification is done. (Please refer to Healthcare Management – Precertification for more details.)

## Surprise Billing Claims and No Surprises Act Requirements

Surprise Billing Claims and No Surprises Act Requirements are described in the **Consolidated Appropriations Act of 2021 Notice** in the **Health Benefits Coverage Under Federal Law** section. Please refer to that section for further details.

## Use the Sydney Mobile App to Connect with Us

As soon as You enroll in the Plan, You should download the mobile app. You can find details on how to do this at www.anthem.com**.** The goal is to make it easy for You to find answers to Your questions.

## How to Find a Provider in the Network

There are four ways You can find out if a Provider or Facility is in the Network for the Plan. You can also find out where they are located and details about their license or training.

- See the Plan's directory of Network Providers at www.anthem.com, which lists the Physician's, Providers and Facilities that participate in the Plan's Network.
- Search for a Provider in Sydney mobile app.
- Call the Accolade Member Services number on the back of Your Member Identification Card to ask for a list of Physicians and Providers that participate in the Plan's Network, based on specialty and geographic area.
- Check with Your Physician or Provider.

If You need details about a Provider's license or training, or help choosing a Physician who is right for You, call the Accolade Member Services number on the back of Your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help Your needs.

## Continuity of Care/Continuation of Care/Transition of Care

If Your Network Provider leaves our Network for any reason other than termination for cause, and You are in active treatment, You may be able to continue seeing that Provider for a limited period of time and still get Network benefits. "Active treatment" includes:

- An ongoing course of treatment for a life-threatening condition.
- An ongoing course of treatment for a serious acute condition (e.g., chemotherapy, radiation therapy, and post-operative visits).
- An ongoing course of treatment for pregnancy and through the postpartum period.

- An ongoing course of treatment for a health condition for which the Physician or healthcare Provider attests that discontinuing care by the current Physician or Provider would worsen Your condition or interfere with anticipated outcomes.

An “ongoing course of treatment” includes treatments for mental health and substance use disorders.

In these cases, You may be able to continue seeing that Provider until treatment is complete, or for 90 days, whichever is shorter. If You wish to continue seeing the same Provider, You should contact Accolade Member Services for details. Any decision by the Plan regarding a request for Continuity of Care/Continuation of Care/Transition of Care is subject to review.

## The BlueCard Program

Like all Blue Cross and Blue Shield plans throughout the country, Anthem participates in a program called “BlueCard,” which provides services to You when You are outside our Service Area. For more details on this program, please refer to “Inter-Plan Arrangements” in the Claims Payment section.

## Copayment

Certain Network services may be subject to a Copayment amount which is a flat-dollar amount You will be charged at the time services are rendered.

Copayments are the responsibility of the Member. Any Copayment amounts required are shown in the **Schedule of Benefits**. Unless otherwise indicated, services which are not specifically identified in this Benefit Booklet as being subject to a Copayment are subject to the Calendar Year Deductible and payable at the percentage payable in the **Schedule of Benefits**.

## Calendar Year Deductible

Before the Plan begins to pay benefits (except certain benefits which are subject to Copayment instead of Deductible), You must meet any Deductible required. You must satisfy one Deductible for each type of coverage as explained in the **Schedule of Benefits**. Deductible requirements are stated in the **Schedule of Benefits**.

# HEALTH CARE MANAGEMENT – PRECERTIFICATION

The Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigative as those terms are defined in this Benefit Booklet. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed. A service must be Medically Necessary to be a Covered Service. When level of care, setting, or place of service is part of the review, services that can be safely given to You in a lower level of care or lower cost setting/place of care, will not be Medically Necessary if they are given in a higher level of care or higher cost setting/place of care.

Certain services must be reviewed to determine Medical Necessity in order for You to get benefits. Utilization Review criteria will be based on many sources, including medical policy and clinical guidelines. The Plan may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate.

If You have any questions regarding the information contained in this section, You may call the Accolade Member Services telephone number on Your Identification Card or visit www.anthem.com.

## Reviewing Where Services are Provided

A service must be Medically Necessary to be a Covered Service. When level of care, setting, or place of service is reviewed, services that can be safely given to You in a lower level of care or lower cost setting/place of care, will not be Medically Necessary if they are given in a higher level of care or higher cost setting/place of care. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens the service can be requested again in another place and will be reviewed again for Medical Necessity. At times, a different Provider or Facility may need to be used in order for the service to be considered Medically Necessary. Examples include, but are not limited to:

- A service may be denied on an Inpatient basis at a Hospital but may be approvable if provided on an outpatient basis at a Hospital.
- A service may be denied on an outpatient basis at a Hospital but may be approvable at a free standing imaging center, infusion center, Ambulatory Surgery Center, or in a Physician's office.
- A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. The Plan may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate. "Clinically equivalent" means treatments that for most Members will give You similar results for a disease or condition.

If You have any questions about the Utilization Review process, the medical policies, or clinical guidelines, You may call the Accolade Member Services telephone number on Your Identification Card or visit www.anthem.com.

**Coverage of or payment for the service or treatment reviewed is not guaranteed even if the Plan decides Your services are Medically Necessary. For benefits to be covered, on the date You get service:**

1. You must be eligible for benefits;
2. Required contributions must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under the Plan;
4. The service cannot be subject to an Exclusion under the Plan; and
5. You must not have exceeded any applicable limits under the Plan.

**Types of Reviews**

- **Pre-service Review** – A review of a service, treatment, or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.

- **Precertification** – A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for You to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigative as those terms are defined in this Benefit Booklet.

  For admissions following Emergency Care, You, Your authorized representative, or doctor should tell the Claims Administrator as soon as You are stabilized. For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require Precertification.

- **Continued Stay/Concurrent Review** – A Utilization Review of a service, treatment, or admission for a benefit coverage determination which must be done during an ongoing stay in a Facility or course of treatment.

Both Pre-Service and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Physician with knowledge of Your medical condition, without such care or treatment, Your life or health or Your ability to regain maximum function could be seriously threatened or You could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter time frame than standard reviews.

- **Post-service Review** – A review of a service, treatment, or admission for a benefit coverage that is conducted after the service has been provided. Post-service Reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service Reviews are done for a service, treatment, or admission in which the Claims Administrator has a related clinical coverage guideline and are typically initiated by the Claims Administrator.

## Failure to Obtain Precertification

**IMPORTANT NOTE: IF YOU OR YOUR OUT-OF-NETWORK PROVIDER DO NOT OBTAIN THE REQUIRED PRECERTIFICATION, CLAIMS WILL BE DENIED FOR NO PRECERTIFICATION. ONCE INFORMATION IS RECEIVED CLAIMS CAN BE RE-OPENED BASED ON MEDICAL INFORMATION PROVIDED. THIS DOES NOT APPLY TO MEDICALLY NECESSARY SERVICES FROM A NETWORK OR BLUECARD PROVIDER.**

**The following Precertification list is not all inclusive and is subject to change; please call Accolade Member Services at the telephone number on Your Identification Card to confirm the most current list and requirements for the Plan.**

**Inpatient Admission:**

- Acute Inpatient
- Acute Rehabilitation
- LTACH (Long Term Acute Care Hospital)
- Skilled Nursing Facility
- OB delivery stays beyond the Federal Mandate minimum LOS (including newborn stays beyond the mother's stay)

**Diagnostic Testing:**

- BRCA Genetic Testing

- Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability (Intellectual Developmental Disorder) and Congenital Anomalies
- Gene Expression Profiling for Managing Breast Cancer Treatment
- Gene Mutation Testing for Cancer Susceptibility and Management
- Genetic Testing for Heritable Cardiac Conditions
- Genetic Testing for Inherited Diseases
- Genetic Testing for Lynch Syndrome, Familial Adenomatous Polyposis (FAP) Attenuated FAP and MYH-Associated Polyposis
- Preimplantation Genetic Diagnosis Testing
- Prostate Saturation Biopsy
- RET Proto-oncogene Testing for Endocrine Gland Cancer Susceptibility
- Wireless Capsule for the Evaluation of Suspected Gastric and Intestinal Motility Disorders

**Durable Medical Equipment (DME)/Prosthetics:**

- Augmentative and Alternative Communication (AAC) Devices with Digitized or Synthesized Speech Output Compression Devices for Lymphedema
- Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
- Implantable Infusion Pumps
- Intrapulmonary Percussive Ventilation (IPV) Device
- Microprocessor Controlled Lower Limb Prosthesis
- Myoelectric Upper Extremity Prosthetic Devices
- Noninvasive Electrical Bone Growth Stimulation of the Appendicular Skeleton
- Standing Frame
- Ultrasound Bone Growth Stimulation
- Wheeled Mobility Devices: Wheelchairs-Powered, Motorized, With or Without Power Seating Systems and Power Operated Vehicles (POVs)

**Gender-Affirming Surgery**

**Human Organ and Bone Marrow/Stem Cell Transplants**

- Inpatient admits for ALL solid organ and bone marrow/stem cell transplants (Including kidney only transplants)
- Outpatient: All procedures considered to be transplant or transplant related including but not limited to:
  - Donor Leukocyte Infusion
  - Intrathecal treatment of Spinal Muscular Atrophy (SMA)
  - Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
  - (CAR) T-cell immunotherapy treatment including but not limited to:
    - Axicabtagene ciloleucel (Yescarta™)
    - Tisagenlecleucel (Kymriah™)
    - Brexucabtagene Autoleucel (Tecartus)
    - lisocabtagene maraleucel (Breyanzi)
    - idecabtagene vicleucel (Abecma)
  - Gene Replacement Therapy. Including, but not limited to:
    - Gene Therapy for Ocular Conditions/ Voretigene neparvovec-rzyl (Luxturna™)
    - Gene Therapy for Spinal Muscular Atrophy/ onasemnogene abeparvovec-xioi (Zolgensma®)

**Mental Health/Substance Abuse (MHSA):**
Precertification Required

- Acute Inpatient Admissions
- Transcranial Magnetic Stimulation (TMS)
- Residential Care
- Behavioral Health in-home Programs
- Applied Behavioral Analysis (ABA)
- Intensive Outpatient Therapy (IOP)
- Partial Hospitalization (PHP)

**Other Outpatient and Surgical Services:**

- Aduhelm (aducanumab)
- Air Ambulance (excludes 911 initiated emergency transport)
- Abdominoplasty and Panniculectomy
- Ablative Techniques as a Treatment for Barrett's Esophagus
- Allogeneic, Xenographic, Synthetic Bioengineered, and Composite Products for Wound Healing and Soft Tissue Grafting
    - Insertion/injection of prosthetic material collagen implants
- Axial Lumbar Interbody Fusion
- Balloon Sinus Ostial Dilation
- Bariatric Surgery and Other Treatments for Clinically Severe Obesity
- Blepharoplasty, Blepharoptosis Repair, and Brow Lift
- Bone-Anchored and Bone Conduction Hearing Aids
- Breast Procedures; including Reconstructive Surgery, Implants, and other Breast Procedures
- Bronchial Thermoplasty
- Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- Cardioverter Defibrillator
- Carotid, Vertebral and Intracranial Artery Stent Placement with or without Angioplasty
- Cervical and Thoracic Discography
- Cochlear Implants and Auditory Brainstem Implants
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System
- Corneal Collagen Cross-Linking
- Cosmetic and Reconstructive Services: Skin Related, including but not limited to:
    - Brachioplasty
    - Chin Implant, Mentoplasty, Osteoplasty Mandible
    - Procedures Performed on the Face, Jaw, or Neck (including facial dermabrasion, scar revision)
- Cosmetic and Reconstructive Services of the Trunk and Groin, including but not limited to:
    - Brachioplasty
    - Buttock/Thigh Lift
    - Congenital Abnormalities
    - Lipectomy/Liposuction
    - Repair of Pectus Excavatum/Carinatum
    - Procedures on the Genitalia

- Cosmetic and Reconstructive Services of the Head and Neck, including but not limited to:
    - Facial Plastic Surgery Otoplasty - Rhinophyma
    - Rhinoplasty or Rhinoseptoplasty (procedure which combines both rhinoplasty and septoplasty)
    - Rhytidectomy (Face lift)
    - Cranial Nerve Procedures
    - Ear or Body Piercing
    - Frown Lines
    - Neck Tuck (Submental Lipectomy)
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain, Cortical, and Cerebellar Stimulation
- Diaphragmatic/Phrenic Nerve Stimulation and Diaphragm Pacing Systems
- Doppler-Guided Transanal Hemorrhoidal Dearterialization (THD)
- Electric Tumor Treatment Field (TTF)
- Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities)
- Extraosseous Subtalar Joint Implantation and Subtalar Arthroereisis
- Functional Endoscopic Sinus Surgery (FESS)
- Home Parenteral Nutrition
- Hyperbaric Oxygen Therapy (Systemic/Topical)
- Immunoprophylaxis for respiratory syncytial virus (RSV)/ Synagis (palivizumab)
- Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry
- Implantable Infusion Pumps
- Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)
- Implanted Devices for Spinal Stenosis
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Keratoprosthesis
- Leadless Pacemaker
- Locoregional and Surgical Techniques for Treating Primary and Metastatic Liver Malignancies
- Lower Esophageal Sphincter Augmentation Devices for the Treatment of Gastroesophageal Reflux Disease (GERD)
- Lysis of Epidural Adhesions
- Mandibular/Maxillary (Orthognathic) Surgery
- Manipulation Under Anesthesia of the Spine and Joints other than the knee and shoulder
- Mastectomy for Gynecomastia
- Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)
- Mechanical Embolectomy for Treatment of Acute Stroke
- Meniscal Allograft Transplantation of the Knee
- Nasal Surgery for the Treatment of Obstructive Sleep Apnea and Snoring
- Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring
- Outpatient Cardiac Hemodynamic Monitoring Using a Wireless Sensor for Heart Failure Management
- Partial Left Ventriculectomy
- Patent Foramen Ovale and Left Atrial Appendage Closure Devices for Stroke Prevention

- Penile Prosthesis Implantation
- Percutaneous and Endoscopic Spinal Surgery
- Percutaneous Neurolysis for Chronic Neck and Back Pain
- Percutaneous Vertebral Disc and Vertebral Endplate Procedures
- Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty
- Perirectal Spacers for Use During Prostate Radiotherapy (Space Oar)
- Photocoagulation of Macular Drusen
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Private Duty Nursing in the Home Setting
- Reduction Mammaplasty
- Sacral Nerve Stimulation (SNS) and Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary and Fecal Incontinence and Urinary Retention
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Sacroiliac Joint Fusion, Open
- Sipuleucel-T (Provenge®) Autologous Cellular Immunotherapy for the Treatment of Prostate Cancer
- Surgical and Ablative Treatments for Chronic Headaches
- Therapeutic Apheresis
- Total Ankle Replacement
- Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins
- Transcatheter Heart Valve Procedures
- Transendoscopic Therapy for Gastroesophageal Reflux Disease, Dysphagia, and Gastroparesis
- Transmyocardial/Perventricular Device Closure of Ventricular Septal Defects
- Treatment of Osteochondral Defects
- Treatment of Varicose Veins (Lower Extremities)
- Treatments for Urinary Incontinence
- Vagus Nerve Stimulation
- Vein Embolization as a Treatment of Pelvic Congestion Syndrome and Varicocele
- Venous Angioplasty with or without Stent Placement/Venous Stenting
- Viscocanalostomy and Canaloplasty
- Wearable Cardioverter Defibrillator

**Out-of-Network Referrals:**
Out-of-Network Services for consideration of payment at Network benefit level (may be authorized, based on Network availability and/or Medical Necessity.)

**Radiation Therapy/ Radiology Services**
- Intensity Modulated Radiation Therapy (IMRT)
- MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications
- Proton Beam Therapy
- Cryosurgical or Radiofrequency Ablation to Treat Solid Tumors Outside the Liver
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Catheter-based Embolization Procedures for Malignant Lesions Outside the Liver
- Wireless Capsule Endoscopy for Gastrointestinal Imaging and the Patency Capsule

**Services not requiring pre-certification for coverage, but recommended for pre-determination of Medical Necessity due to the existence of post service claim edits and/or the potential cost of services to the Member if denied by Anthem for lack of Medical Necessity:**

Procedures, equipment, and/or specialty infusion drugs which have Medically Necessary criteria determined by Corporate Medical Policy or Adopted Clinical Guidelines.

Utilizing a Provider outside of the Network may result in significant additional financial responsibility for You because the Plan cannot prohibit Out-of-Network Providers from billing You for the difference between the Provider's charge and the benefit the Plan provides.

The ordering Provider, Facility or attending Physician ("requesting Provider") should contact the Claims Administrator to request a Precertification or Pre-service Review. The Claims Administrator will work directly with the requesting Provider for the Precertification request. However, You may designate an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

## Who is Responsible for Precertification?

Typically, Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the requesting Provider will get in touch with the Claims Administrator to ask for a Precertification. However, You may request a Precertification or You may choose an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

| Provider Network Status | Responsibility to Get Precertification | Comments |
|---|---|---|
| Network, including BlueCard Providers in the service areas of Anthem Blue Cross and Blue Shield (CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI); Anthem Blue Cross (CA); Empire Blue Cross Blue Shield; Anthem Blue Cross Blue Shield (GA); and any future affiliated Blue Cross and/or Blue Shield plans resulting from a merger or acquisition by the Claims Administrator's parent company. | Provider | • The Provider must get Precertification when required |
| Out-of-Network/Non-Participating | Member | • Member must get Precertification when required. (Call Accolade Member Services.)<br>• Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary. |
| Blue Card Provider outside the service areas of the states listed in the | Member<br>(Except for Inpatient Admissions) | • Member must get Precertification when required. (Call Accolade Member Services.) |

| Provider Network Status | Responsibility to Get Precertification | Comments |
|---|---|---|
| column above and BlueCard Providers in other states not listed | | • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.<br>• **Blue Card Providers must obtain Precertification for all Inpatient Admissions.** |
| **NOTE: For an Emergency care admission, Precertification is not required.** | | |

The Claims Administrator will utilize its clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make Medical Necessity decisions. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The Claims Administrator reserves the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning Your request. To ask for this information, call the Precertification phone number on the back of Your Identification Card.

If You are not satisfied with the Plan's decision under this section of Your benefits, please refer to the **Your Right To Appeal** section to see what rights may be available to You.

**Decision and Notice Requirements**
The Claims Administrator will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on Federal laws. You may call the phone number on the back of Your Identification Card for more details.

| Type of Review | Timeframe Requirement for Decision and Notification |
|---|---|
| Urgent Pre-service Review | 72 hours from the receipt of request |
| Non-Urgent Pre-service Review | 15 calendar days from the receipt of the request |
| Urgent Continued Stay/Concurrent Review when request is received more than 24 hours before the end of the previous authorization | 24 hours from the receipt of the request |
| Urgent Continued Stay/Concurrent Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists | 72 hours from the receipt of the request |
| Non-urgent Continued Stay/Concurrent Review for ongoing outpatient treatment | 15 calendar days from the receipt of the request |
| Post-Service Review | 30 calendar days from the receipt of the request |

If more information is needed to make a decision, the Claims Administrator will tell the requesting Provider of the specific information needed to finish the review. If the Claims Administrator does not get the specific information needed by the required timeframe, the Claims Administrator will make a decision based upon the information it has.

The Claims Administrator will notify You and Your Provider of its decision as required by Federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

## Important Information

From time to time certain medical management processes (including utilization management) may be waived, enhanced, changed or ended. An alternate benefit may be offered if, in the Plan's sole discretion, such change furthers the provision of cost effective, value based and/or quality services.

Certain qualifying Providers may be selected to take part in a program or a Provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. You claim may also be exempted from medical review if certain conditions apply.

Just because a process, Provider or claim is exempted from the standards which otherwise would apply, it does not mean that this will occur in the future, or will do so in the future for any other Provider, claim or Member. The Plan may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs or a Provider arrangement by contacting the Accolade Member Services number on the back of Your Identification Card.

The Claims Administrator also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then the Claims Administrator may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to the Plan's Members.

# BENEFITS

**The Benefits in this section apply to the Copay Plan, Lower Deductible HSA Plan and the Higher Deductible HSA Plan. Payment terms apply to all Covered Services. Please refer to the appropriate Schedule of Benefits for details. All Covered Services must be Medically Necessary, whether provided through Network Providers or Out-of-Network Providers.**

## Acupuncture

Treatment of neuromusculoskeletal pain by an acupuncturist who acts within the scope of their license. Treatment involves using needles along specific nerve pathways to ease pain.

## Ambulance Service

Medically Necessary Ambulance Services are a Covered Service when:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

And one or more of the following criteria are met:

- For ground ambulance, You are taken:
  - From Your home, the scene of an accident, or Medical Emergency to a Hospital.
  - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network hospital.
  - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, You are taken:
  - From the scene of an accident or Medical Emergency to a Hospital.
  - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital.
  - Between a Hospital and an approved Facility.

Ambulance Services are subject to Medical Necessity reviews by the Claims Administrator. Emergency ground Ambulance Services do not require Precertification and are allowed regardless of whether the Provider is a Network or Out-of-Network Provider.

Non-emergency Ambulance Services are subject to Medical Necessity reviews by the Claims Administrator. When using an air ambulance, for non-emergency transportation, the Claims Administrator reserves the right to select the air ambulance Provider. If You do not use the air ambulance Provider the Claims Administrator selects, the Out-of-Network Provider may bill You for any charges that exceed the Plan's Maximum Allowed Amount, subject to the No Surprises Act's requirements.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases the Claims Administrator may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or Injury by medical professionals from an Ambulance Service, even if You are not taken to a Facility.

Ambulance Services are not covered when another type of transportation can be used without endangering Your health. Ambulance Services for Your convenience or the convenience of Your family or Physician are not a Covered Service.

Other non-covered Ambulance Services include, but are not limited to:

- a Physician's office or clinic; or
- a morgue or funeral home.

**Important Notes on Air Ambulance Benefits**
Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger Your health and Your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if You are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if You are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility or a rehabilitation Facility), or if You are taken to a Physician's office or Your home, subject to the No Surprises Act's requirements.

**Hospital to Hospital Transport**
If You are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger Your health and if the Hospital that first treats cannot give You the medical services You need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, You must be taken to the closest Hospital that can treat You. **Coverage is not available for air ambulance transfers simply because You, Your family, or Your Provider prefers a specific Hospital or Physician.**

## Assistant Surgery
Services rendered by an assistant surgeon are covered based on Medical Necessity.

## Breast Cancer Care

Covered Services are provided for Inpatient care following a mastectomy or lymph node dissection until the completion of an appropriate period of stay as determined by the attending Physician in consultation with the Member. Follow-up visits are also included and may be conducted at home or at the Physician's office as determined by the attending Physician in consultation with the Member.

## Breast Reconstructive Surgery
Covered Services are provided following a mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas.

## Cardiac Rehabilitation
Covered Services are provided as outlined in the **Schedule of Benefits**.

## Clinical Trials
Benefits include coverage for services, such as routine patient care costs, given to You as a participant in an approved clinical trial if the services are Covered Services under the Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
   a. The National Institutes of Health.
   b. The Centers for Disease Control and Prevention.
   c. The Agency for Health Care Research and Quality.
   d. The Centers for Medicare & Medicaid Services.
   e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
   f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

i. The Department of Veterans Affairs.
ii. The Department of Defense.
iii. The Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

The Plan may require You to use a Network Provider to maximize Your benefits.

Routine patient care costs include items, services and drugs provided to You in connection with an approved clinical trial that would otherwise be covered by the Plan.

All other requests for clinical trials services, including requests that are not part of approved clinical trials, will be reviewed according to the Claims Administrator's Clinical Coverage Guidelines, related policies and procedures.

The Plan is not required to provide benefits for the following services. The Plan reserves the right to exclude any of the following services:

1. The Experimental/Investigative item, device, or service; or
2. Items used and services that are provided only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

## Consultation Services

Covered when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or Injury. Second surgical opinion consultations are covered.

Staff consultations required by Hospital rules are excluded. Referrals (the transfer of a patient from one Physician to another for treatment) are not consultations under the Plan.

## Dental Services

**Related to Accidental Injury**

The Plan includes benefits for dental work required for the initial repair of an Accidental Injury to the jaw, sound natural teeth, mouth or face which are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Member's condition. Injury as a result of chewing or biting is not considered an Accidental Injury except where the chewing or biting results from an act of domestic violence or directly from a medical condition.

## Diabetes

Equipment and outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes as prescribed by the Physician. Covered Services for outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes. Screenings for gestational diabetes are covered under "Preventive Services."

## Dialysis Treatment

The Plan covers Covered Services for Dialysis treatment. If applicable, the Plan will pay secondary to Medicare Part B after the expiration of the 30 month coordination period, even if a Member has not applied for or is not enrolled in eligible coverage available through Medicare.

## Durable Medical Equipment (DME), Medical Devices, and Supplies

The Plan will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity, and applicable Precertification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the Member's medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.

The equipment must meet the following criteria:

- It can stand repeated use.
- It is manufactured solely to serve a medical purpose.
- It is not merely for comfort or convenience.
- It is normally not useful to a person not ill or Injured.
- It is ordered by a Physician.
- The Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. The Plan may require proof at any time of the continuing Medical Necessity of any item.
- It is related to the Member's physical disorder.

Equipment, devices, supplies, and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in Your situation will not be covered. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is Your responsibility.

## Emergency Services

**Life-threatening Medical Emergency or serious Accidental Injury.**

Coverage is provided for Hospital emergency room or freestanding emergency Facility care, including a medical or mental health screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Medical Condition, and within the capabilities of the staff and Facilities available at the Hospital, such further medical or mental health examination and treatment as are required to Stabilize the patient. Emergency Service care does not require any Prior Authorization from the Plan.

Stabilize means, with respect to an Emergency Medical Condition: to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a Facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Medically Necessary services will be covered whether You get care from a Network or Out-of-Network Provider. Emergency Care You get from an Out-of-Network Provider will be covered as a Network service and will not require Precertification. The Out-of-Network Provider can only charge You any applicable Deductible, Coinsurance, and/or Copayment and cannot bill You for the difference between the Maximum Allowed Amount and their billed charges until Your condition is stable as described in the Consolidated Appropriations Act of 2021 Notice in the Health Benefits Coverage Under Federal Law section. Your cost-shares will be based on the Maximum Allowed Amount and will be applied to Your Network Deductible and Network Out-of-Pocket Limit.

Treatment You get after Your condition has stabilized is not Emergency care. Please refer to the **Consolidated Appropriations Act of 2021 Notice** in the **Health Benefits Coverage Under Federal Law** section for more details on how this will impact Your benefits.

The Maximum Allowed Amount will be used to determine payment for Emergency Care from an Out-of-Network Provider. However, Member cost-share will be based on the median Plan Network contract rate paid to Network Providers for the geographic area where the service is provided.

The Copayment and/or Coinsurance payable for both Network and Out-of-Network are shown in the **Schedule of Benefits**.

## Gender-Affirming Surgery and Services

Benefits for the treatment of Gender Dysphoria limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses

- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a Physician (for example during an office visit)
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

Male to Female:

- Clitoroplasty (creation of clitoris)
- Labiaplasty (creation of labia)
- Orchiectomy (removal of testicles)
- Penectomy (removal of penis)
- Urethroplasty (reconstruction of female urethra)
- Vaginoplasty (creation of vagina)

Female to Male:

- Bilateral mastectomy or breast reduction
- Hysterectomy (removal of uterus)
- Metoidioplasty (creation of penis, using clitoris)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

**Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:**
The Member must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified mental health Provider experienced in treating Gender Dysphoria. The assessment must document that the Member meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Member must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified mental health Providers experienced in treating Gender Dysphoria, who have independently assessed the Member. The assessment must document that the Member meets all of the following criteria.
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.

- Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

## Gene Therapy Services

The Plan includes benefits for gene therapy services, when Anthem approves the benefits in advance through Precertification. See **Health Care Management - Precertification** for details on the Precertification process. To be eligible for coverage, services must be Medically Necessary and performed by an approved Provider at an approved treatment center. Even if a Provider is a Network Provider for other services it may not be an approved Provider for certain gene therapy services. Please call us to find out which providers are approved Providers.

**Services Not Eligible for Coverage**

The Plan does not include benefits for the following:

- Services determined to be Experimental/Investigational;
- Services provided by a non-approved Provider or at a non-approved Facility; or
- Services not approved in advance through Precertification.

## General Anesthesia Services

Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure.

- Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:
- spinal or regional anesthesia;
- injection or inhalation of a Drug or other agent (local infiltration is excluded).

Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are only covered when billed by the supervising anesthesiologist, subject to the requirements of the No Surprises Act.

## Habilitative Services

Benefits also include habilitative health care services and devices that help You keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of Inpatient and/or outpatient settings.

## Home Health Care Services

Home Health Care provides a program for the Member's care and treatment in the home. Your coverage is outlined in the **Schedule of Benefits**. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching, and nursing services consistent with the diagnosis, established and approved in writing by the Member's attending Physician. Services may be performed by either Network or Out-of-Network Providers.

**Some special conditions apply:**

- The Physician's statement and recommended program must be pre-certified.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis. Note: Covered Services available under Home Health Care do NOT reduce outpatient benefits available under the Physical Therapy section shown in the Plan.

**Covered Services:**

- Visits by a Registered Nurse ("RN") or Licensed Practical Nurse ("LPN"). Benefits cannot be provided for services if the nurse is related to the Member.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed medical social services worker when Medically Necessary to enable the Member to understand the emotional, social, and environmental factors resulting from or affecting the Member's illness.
- Visits by a Home Health Care nursing aide when rendered under the direct supervision of an RN.

- Nutritional guidance when Medically Necessary.
- Oxygen and its administration.

Covered Services for Home Health Care do not include:

- Food, housing, homemaker services, sitters, home-delivered meals;
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care;
- Services and/or supplies which are not included in the Home Health Care plan as described;
- Services of a person who ordinarily resides in the Member's home or is a member of the family of either the Member or Member's Spouse;
- Any services for any period during which the Member is not under the continuing care of a Physician;
- Convalescent or Custodial Care where the Member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the Member;
- Any services or supplies not specifically listed as Covered Services;
- Routine care and/or examination of a newborn child;
- Dietician services;
- Maintenance therapy;
- Dialysis treatment; or
- Purchase or rental of dialysis equipment.

## Hospice Care Services

You are eligible for Hospice care if Your Physician and the Hospice medical director certify that You are terminally ill and likely to have less than twelve (12) months to live. You may access a Hospice Care Program while participating in a clinical trial or continuing disease modifying therapy, as ordered by Your treating Provider. Disease modifying therapy treats the underlying terminal illness.

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care;
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care;
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of an RN;
- Social services and counseling services from a licensed social worker;
- Nutritional support such as intravenous feeding and feeding tubes;
- Physical Therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist;
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of Your condition, including oxygen and related respiratory therapy supplies; and
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver, and individuals with significant personal ties for one year after the Member's death.

Your Physician must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to the Claims Administrator upon request.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to, chemotherapy and radiation therapy, are available to a Member in Hospice. These services are covered under other parts of this Benefit Booklet.

## Hospital Services

You may receive treatment at a Network or an Out-of-Network Hospital. However, payment is significantly reduced if services are received at an Out-of-Network Hospital. The Plan provides Covered Services when the following services are Medically Necessary.

**Network**

Inpatient Services

- Inpatient room charges. Covered Services include Semiprivate Room and board, general nursing care, and intensive or cardiac care. If You stay in a private room, the Maximum Allowed Amount is based on the Hospital's prevalent Semiprivate Room rate. If You are admitted to a Hospital that has only private rooms, the Maximum Allowed Amount is based on the Hospital's prevalent room rate.

Service and Supplies

- Services and supplies provided and billed by the Hospital while You're an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation, and speech therapy are also covered.
- Convenience items (such as radios, TV's, records, tapes or CD players, telephones, visitors' meals, etc.) will not be covered.

Length of Stay

- Determined by Medical Necessity

**Out-of-Network**

- Hospital Benefits

If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the **Schedule of Benefits** section.

## Hospital Visits

The Physician's visits to his or her patient in the Hospital. Covered Services are limited to one daily visit for each attending Physician specialty during the covered period of confinement.

## Human Organ and Tissue Transplant Services

**Precertification**

**To maximize Your benefits, You need to call Accolade to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. Your evaluation and work up services must be provided by a Blue Distinction Center + or Blue Distinction Center Transplant Provider to receive the maximum benefits.**

Contact Accolade and ask for the transplant coordinator. Accolade will then assist You in maximizing Your benefits by providing coverage information including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements or Benefit Booklet exclusions are applicable. Even if the Claims Administrator issues a prior approval for the Covered Transplant Procedure, You or Your Provider must call the Accolade Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or outpatient setting. Failure to obtain this information prior to receiving services could result in financial responsibility for the Member.

Please note that there are instances where Your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

**Covered Transplant Benefit Period**

At a Blue Distinction Center + or Blue Distinction Center Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts for the applicable case rate/global time period.

The number of days will vary depending on the type of transplant received and the Blue Distinction Center + or Blue Distinction Center Transplant Provider agreement. Call Accolade for specific Network Transplant Provider details for services received at or coordinated by a Network Transplant Provider Facility.

**Transportation and Lodging**
The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Claims Administrator when You obtain prior approval and are required to travel more than **50** miles from Member's home to reach the Facility where Your Covered Transplant Procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the Facility and lodging for the transplant recipient Member and one companion for an adult Member, or two companions for a child patient. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Claims Administrator when claims are filed. Contact Accolade for detailed information. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

## Licensed Speech Therapist Services
Services must be ordered and supervised by a Physician as outlined in the **Schedule of Benefits**. Speech therapy is not covered when rendered for the treatment of Developmental Delay.

## Maternity Care and Reproductive Health Services
Covered Services are provided for Network Maternity Care as stated in the **Schedule of Benefits**. If You choose an Out-of-Network Provider, benefits are subject to the Deductible and percentage payable provisions as stated in the **Schedule of Benefits**.

Routine newborn nursery care is part of the mother's maternity benefits. Benefits are provided for well-baby pediatrician visits performed in the Hospital.

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name.

Under Federal law, the Plan may not restrict the length of stay to less than the 48/96 hour periods or require Precertification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the Member's attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the Member will have access to two post-discharge follow-up visits within the 48 or 96 hour period. These visits may be provided either in the Physician's office or in the Member's home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of Provider rendering the service will be made by the Member's attending Physician.

**Abortion (Therapeutic or Elective)**
The Plan includes benefits for a therapeutic abortion, which is an abortion recommended by a Provider that is performed to save the life or health of the mother, or as a result of incest or rape. The Plan also provides benefits for an elective (voluntary) abortion, which is an abortion performed for reasons other than those described above.

**Contraceptive Benefits**
Benefits include oral contraceptive Drugs, injectable, contraceptive Drugs, and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Services" benefit. Please refer to that section for further details.

**Fertility Services**
The Plan also includes benefits for the diagnosis and treatment of Infertility.

Covered Services include:

- Diagnostic and exploratory procedures to determine whether a Member suffers from Infertility.
- Surgical procedures to correct a diagnosed disease or condition affecting the reproductive organs. This includes, but is not limited to, endometriosis, (tissue lining the uterus moves to other parts of the body), collapsed/clogged fallopian tubes or testicular failure.
- Covered fertilization services include, but are not limited to:
    - Artificial insemination,

- In-vitro fertilization,
- GIFT (gamete intra-fallopian transfer),
- ZIFT (zygote intra-fallopian transfer) procedures,
- Egg/Sperm/Embryo cryopreservation with 1 year of storage when done in conjunction with a covered fertility treatment,
- Elective egg/sperm cryopreservation coverage – 1 year of storage
- Pre-implantation Genetic Screening (PGS) when medically appropriate,
- Pre-implantation Genetic Diagnosis (PGD) when medically appropriate,
- Frozen Embryo Transfers (FET),
- Management of ovulation induction,
- Assisted Reproductive Technologies (ART),

Please refer to the **Schedule of Benefits** for benefit limitations, Coinsurance and Copayment amounts.

**Exclusions and Limitations include, but not limited to:**

- Ovulation predictor kits,
- Reversal of tubal ligations; Only covered if medically necessary,
- Reversal of vasectomies; Only covered if medically necessary,
- Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue,
- Adoption services,
- Surrogacy and any fees associated with it,
- Cloning,
- Medical and surgical procedures that are experimental or investigational.

**Sterilization Services**

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or Injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Services" benefit.

## Medical Care

Benefits include general diagnostic care and treatment of illness or Injury. Some procedures require Precertification.

## Mental Healthcare and Substance Abuse Treatment

See the **Schedule of Benefits** for any applicable Deductible, Coinsurance, and Copayment information. Coverage for the diagnosis and treatment of Mental Healthcare and Substance Abuse Treatment on an Inpatient or outpatient basis will not be subject to Deductibles, Coinsurance, or Copayment provisions that are less favorable than the Deductible, Coinsurance, or Copayment provisions that apply to a physical illness as covered under this Benefit Booklet.

Covered Services include the following:

- **ABA Therapy** – Medically Necessary applied behavioral analysis services.
- **Inpatient Services** in a Hospital or any Facility that must be covered by law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and Detoxification.
- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:
  - observation and assessment by a psychiatrist weekly or more often; and
  - rehabilitation and therapy.

- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, Intensive Outpatient Programs, and (when available in Your area) Intensive In-Home Mental Health Programs that participate in the Network.
- **Online Visits** when available in Your area. Covered Services include a visit with the Physician using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Physician to Physician discussions (Online Visits are also available through Anthem.com or the Sydney App).

Examples of Providers from whom You can receive Covered Services include:

- Psychiatrist
- Psychologist
- Licensed Clinical Social Worker (LCSW)
- Mental Health Clinical Nurse Specialist
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Counselor (LPC)
- Any agency licensed by the state to give these services, when they have to be covered by law.

## Nutritional Counseling
Benefits include nutritional counseling related to the medical management of a disease state as stated in the **Schedule of Benefits**.

## Obesity
Prescription Drugs and any other services or supplies for the treatment of obesity are not covered. Surgical treatment of obesity is only covered for patients meeting Medical Necessity criteria, as defined by the Plan.

## Online Visits
Please refer to Virtual Video Visits (LiveHealth Online) and Virtual Primary Care in this section. Please refer to Telehealth in the Definitions section.

## Out-of-Network Freestanding Ambulatory Surgery Center
Any services rendered or supplies provided while You are a patient or receiving services at or from an Out-of-Network Freestanding Ambulatory Surgery Center will be payable at the Out-of-Network Maximum Allowed Amount.

## Out-of-Network Hospital Benefits
If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the **Schedule of Benefits** section.

## Oral Surgery
Covered Services include only the following:

- Fracture of facial bones
- Removal of impacted teeth
- Lesions of the mouth, lip, or tongue which require a pathological exam
- Incision of accessory sinuses, mouth salivary glands, or ducts
- Dislocations of the jaw
- Plastic repair of the mouth or lip necessary to correct traumatic Injuries or congenital defects that will lead to functional impairments
- Initial services, supplies, or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to sound natural teeth or structure occurring while a Member is covered by the Plan.

Although the Plan covers certain oral surgeries as listed above, many oral surgeries are not covered. Covered Services also include the following:

- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral/surgical correction of Accidental Injuries as indicated in the “Dental Services” section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue, not including odontogenic cysts or abscesses.

## Other Covered Services

The Plan provides Covered Services when the following services are Medically Necessary:

- Chemotherapy and radioisotope, radiation, and nuclear medicine therapy
- Diagnostic x-ray and laboratory procedures
- Dressings, splints, and casts when provided by a Physician
- Oxygen, blood and components, and administration
- Pacemakers and electrodes
- Use of operating and treatment rooms and equipment.

## Outpatient CT Scans and MRIs

These services are covered at regular Plan benefits.

## Outpatient Hospital Services

The Plan provides Covered Services when the following outpatient services are Medically Necessary: pre-admission tests, surgery, diagnostic x-rays and laboratory services. Certain procedures require Precertification.

## Outpatient Surgery

Network Hospital outpatient department or Network Freestanding Ambulatory Surgery Center charges are covered at regular Plan benefits. Benefits for treatment by an Out-of-Network Hospital are explained under “Hospital Services.”

## Physical Therapy, Occupational Therapy, Manipulation Therapy

Services by a Physician, a registered physical therapist (R.P.T.), a licensed occupational therapist (O.T.) or a licensed chiropractor (D.C.) as outlined in the **Schedule of Benefits**. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual Provider. No coverage is available when such services are necessitated by Developmental Delay.

## Physician Services

You may receive treatment from a Network or Out-of-Network Physician. However, payment is significantly reduced if services are received from an Out-of-Network Physician. Such services are subject to Your Deductible and Out-of-Pocket requirements. Consultations between Your Primary Care Physician and a Specialty Care Physician are included, when approved by the Claims Administrator.

## Preventive Services

Preventive Services include screenings and other services for adults and children and are dependent on age, gender and health condition. All recommended preventive services will be covered as required by the Affordable Care Act (ACA). This means many preventive care services are covered at 100% with no Deductible, Copayment or Coinsurance when You use a Network Provider provided they meet specific criteria as determined by the Department of Health and Human Services and provided at hhs.gov/healthcare/about-the-aca/preventive-care/index.html. The Plan may allow You to receive these services from an Out-of-Network Provider, but may charge you a fee.

Certain benefits for Members who have current symptoms, or a diagnosed health problem may be covered under diagnostic services instead of this benefit for Preventive Services, if the coverage does not fall within ACA-recommended preventive services. In addition, Your Physician may provide a service, such as a cholesterol-screening test, as part of an office visit. Accordingly, if the Preventive Service is not the primary purpose of the visit or if Your Physician bills You for the Preventive Services separately from the office visit, then the Plan could require

You to pay some costs of the office visit. Please contact Your Provider to determine whether services will be covered as a Preventive Service.

Covered Services fall under the following broad groups:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force.

Examples of these services are screenings for:

a. Breast cancer
b. Cervical cancer
c. Colorectal cancer
d. High blood pressure
e. Type 2 Diabetes Mellitus
f. Cholesterol
g. Unhealthy drug use screening
h. Child and adult obesity.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
3. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
   a. Women’s contraceptives, sterilization procedures, and counseling. Coverage includes contraceptive devices, such as diaphragms, intra uterine devices (IUDs), and implants.
   b. Breastfeeding support, supplies, and counseling.
   c. Gestational diabetes screening.
5. Preventive care services for smoking cessation and tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
   a. Counseling

You may call Accolade Member Services using the number on Your Identification Card for additional information about these services or view the Federal government’s web sites, http://www.healthcare.gov/center/regulations/prevention.html, http://.ahrq.gov. and http://www.cdc.gov/vaccines/acip/index.html.

## Preventive Care for Chronic Conditions (per the Treasury Department, Internal Revenue Service (IRS), and Department of Health and Human Services (HHS) guidelines)

The following benefits are available if the care qualifies under guidelines provided by the Treasury Department, Internal Revenue Service (IRS), and Department of Health and Human Services (HHS).

| Preventive Care for Specified Conditions | For Individuals Diagnosed with |
|---|---|
| Angiotensin Converting Enzyme (ACE) inhibitors | Congestive heart failure, diabetes, and/or coronary artery disease |
| Anti-resorptive therapy | Osteoporosis and/or osteopenia |
| Beta-blockers | Congestive heart failure and/or coronary artery disease |
| Blood pressure monitor | Hypertension |
| Inhaled corticosteroids | Asthma |
| Insulin and other glucose lowering agents | Diabetes |
| Retinopathy screening | Diabetes |

| Preventive Care for Specified Conditions | For Individuals Diagnosed with |
|---|---|
| Peak flow meter | Asthma |
| Glucometer | Diabetes |
| Hemoglobin A1c testing | Diabetes |
| International Normalized Ratio (INR) testing | Liver disease and/or bleeding disorders |
| Low-density Lipoprotein (LDL) testing | Heart disease |
| Selective Serotonin Reuptake Inhibitors (SSRIs) | Depression |
| Statins | Heart disease and/or diabetes |

The agencies will periodically review the list of preventive care services and items to determine whether additional services or items should be added or if any should be removed from the list. You will be notified if updates are incorporated into the Plan.

Please refer to the **Schedule of Benefits** for further details on how benefits will be paid.

## Prosthetic Appliances

Prosthetic devices to improve or correct conditions resulting from Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician.

Prosthetic devices include: artificial limbs and accessories; artificial eyes, one pair of glasses, or contact lenses for eyes used after surgical removal of the lens of the eye(s); arm braces; leg braces (and attached shoes); and external breast prostheses used after breast removal.

The following items are excluded: corrective shoes; dentures; replacing teeth or structures directly supporting teeth (except to correct traumatic Injuries); electrical or magnetic continence aids (either anal or urethral); and implants for cosmetic purposes except for reconstruction following a mastectomy.

## Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, Injury, or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy.

Note: Coverage for reconstructive services does not apply to orthognathic surgery. Please refer to the “Oral Surgery” section above for that benefit.

## Retail Health Clinic

Benefits are provided for Covered Services received at a Retail Health Clinic.

## Skilled Nursing Facility Care

Benefits are provided as outlined in the Schedule of Benefits. This care must be ordered by the attending Physician. All Skilled Nursing Facility admissions must be pre-certified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

- A favorable prognosis.
- A reasonably predictable recovery time.
- Services and/or Facilities less intense than those of the acute general Hospital, but greater than those normally available at the Member’s residence.

Covered Services include:

- Semiprivate or ward room charges including general nursing service, meals, and special diets. If a Member stays in a private room, the Plan pays the Semiprivate Room rate toward the charge for the private room.
- Use of special care rooms.

- Pathology and radiology.
- Physical or speech therapy.
- Oxygen and other gas therapy.
- Drugs and solutions used while a patient.
- Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician's continuous care and 24 hour-a-day nursing care.

Benefits will not be provided when:

- A Member reaches the maximum level of recovery possible and no longer requires other than routine care.
- Care is primarily Custodial Care, not requiring definitive medical or 24 hour-a-day nursing service.
- No specific medical conditions exist that require care in a Skilled Nursing Facility.
- The care rendered is for other than Skilled Convalescent Care.

## Surgical Care

Surgical procedures including the usual pre- and post-operative care. Some procedures require Precertification. Bariatric, Infertility, Orthopedic and Transplant services are only available at Blue Distinction Centers. Please refer to "Blue Distinction Surgery Providers" in the **Definitions** section for further information.

## Treatment of Accidental Injury in a Physician's Office

All outpatient surgical procedures related to the treatment of an Accidental Injury, when provided in a Physician's office, will be covered under the Member's Physician's office benefit.

## Virtual Primary Care

Through Anthem's website, www.anthem.com and Anthem's Sydney Health mobile application, Anthem Members have access to convenient, affordable on-demand and scheduled secure medical text-chat and video visits for Urgent Care and primary care spanning Urgent Care, prevention and wellness, and condition management for adults ages 18-64. Anthem's virtual care experience also provides Members with care guidance through a variety of tools such as the AI-driven symptom checker for assessing their symptoms prior to receiving virtual medical care.

Our virtual primary care service offers Members:

- comprehensive primary care, coordinated by a care team;
- 24/7, on-demand Urgent Care support;
- full preventive care wellness exam;
- chronic condition visits;

personalized care plans and follow-ups; and

- unlimited access to care, including Prescription refills and referrals.

## Virtual Video Visits (LiveHealth Online)

When available in Your area, Your coverage will include Virtual Video Visits. Covered Services include a medical consultation using the internet via a webcam, or voice. Please refer to "Physician Services" in the **Schedule of Benefits** section for any applicable Deductible, Coinsurance, Copayment, and benefit limitation information. For mental health and substance abuse Virtual Video Visits, please refer to "Mental Healthcare and Substance Abuse Treatment" in the **Schedule of Benefits** section. Non-Covered Services include, but are not limited to, communications used for:

- Reporting normal lab or other test results
- Office appointment requests
- Billing, insurance coverage or payment questions
- Requests for referrals to Physicians outside of the online care panel
- Benefit Precertification
- Physician-to-Physician consultation

## Managing Specialty Medications

If You are utilizing a Specialty Drug, our goal is to provide You with access to the most clinically appropriate therapy to meet Your treatment needs. These Drugs are used to treat complicated and chronic conditions, such as cancer, rheumatoid arthritis, multiple sclerosis, and other diseases. Health issues like these can be challenging to manage and we want to assure that You receive safe, effective treatment.

Anthem also requires Precertification for certain Specialty Drugs. This means that a clinical review is required before the Specialty Drug is approved. Precertification assures consistent use of effective medications based on our medical policies and treatment guidelines. We also review for correct dose and frequency as well. Your Physician will contact us for Precertification and provide us with the clinical information needed for us to review the request.

Our focus is also on the setting in which Your treatment may occur. There are multiple options available to You typically selected by Your Physician. The outpatient hospital setting can be 2-3 times more costly than other sites. Receiving care in a lower cost site which can meet Your specific needs can help You and Your Employer save money and can also possibly provide You with more convenient options in which to receive Your Specialty Drug treatment. Anthem's Site of Care program requires that Your prescriber provide information on the level of care that You need. You may be redirected to receive Your care in Your Physician's office, an infusion center, or from a home infusion Provider instead of the outpatient Hospital.

These approaches work cohesively together to help You with Your medical Specialty Drug needs.

## Prescription Drugs Administered by a Medical Provider

The Plan covers Prescription Drugs, including Specialty Drugs, that must be administered to You as part of a Physician's visit, Home Health Care visit, or at an outpatient Facility when they are Covered Services. This may include Drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any Drug that must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to You in a medical setting. Benefits for Drugs You inject or get from a retail pharmacy (i.e., self-administered Drugs) are not covered.

### Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under Federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider, and controlled substances must be prescribed by a licensed Provider with an active DEA license.

Compound Drugs are a Covered Service when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound Drug are FDA approved, require a prescription to dispense, and are not essentially the same as an FDA approved product from a Drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

### What's Not Covered

1. Compound Drugs will not be covered unless all of the ingredients are FDA approved and cannot be essentially the same as an FDA-approved Prescription product already on the market. The ingredients in the compound must also require a Prescription to dispense. This means that if the compound contains ingredients that may be purchased over-the-counter, it would not be covered. Ingredients such as the compound base ingredient (non-proprietary cream, ointment, or like product) or an adjuvant are not subject to these limitations.
2. Drugs not approved by the FDA.

### Important Details About Prescription Drug Coverage

The Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, Your prescribing Physician may be asked to give more details before the Plan decides if the Prescription Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, the Claims Administrator has established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration.

- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease.
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation, and Mitigation Strategies).
- Step therapy, requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated,
- Use of an Anthem Prescription Drug List (a Formulary developed by the Claims Administrator which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost-effectiveness.

**Precertification**
Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines for Prescription Drug coverage are followed. The Claims Administrator will give the results of the Plan's decision to both You and Your Provider.

For a list of Prescription Drugs that need Precertification, please call the phone number on the back of Your Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under the Plan. Your Provider may check with the Claims Administrator to verify Prescription Drug coverage, to find out which drugs are covered under this section, and if any drug edits apply.

Please refer to the section **Health Care Management – Precertification** for more details.

If Precertification is denied, You have the right to file an appeal as outlined in the Your Right to Appeal section of this Benefit Booklet.

**Designated Pharmacy Provider**
The Plan in its sole discretion, may establish one or more Designated Pharmacy Provider programs which provide specific Pharmacy services (including shipment of Prescription Drugs) to Members. A Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the Network Provider must have signed a Designated Pharmacy Provider Agreement with the Claims Administrator. You or Your Provider can contact Accolade Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

For Prescription Drugs that are shipped to You or Your Provider and administered in Your Provider's office, You and Your Provider are required to order from a Designated Pharmacy Provider. A Patient Care coordinator will work with You and Your Provider to obtain Precertification and to assist shipment to Your Provider's office.

You may also be required to use a Designated Pharmacy Provider to obtain Prescription Drugs for treatment of certain clinical conditions such as hemophilia. The Plan reserves the right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to You. The Plan may from time to time, change with or without advance notice, the Designated Pharmacy Provider for a Drug, if in the Plan's discretion, such change can help provide cost-effective, value based and/or quality services.

If You are required to use a Designated Pharmacy Provider and You choose not to obtain Your Prescription Drug from a Designated Pharmacy Provider, coverage will be provided at the Out-of-Network level.

You can get the list of the Prescription Drugs covered under this section by calling Accolade Member Services at the phone number on the back of Your Identification Card or check the Claims Administrator's website at www.anthem.com.

**Therapeutic Substitution**
Therapeutic substitution is an optional program that tells You and Your Providers about alternatives to certain prescribed Drugs. The Claims Administrator may contact You and Your Provider to make You aware of these choices. Only You and Your Provider can determine if the therapeutic substitute is right for You. For questions or issues about therapeutic Drug substitutes, call Accolade Member Services at the phone number on the back of Your Identification Card.

# LIMITATIONS AND EXCLUSIONS

1. **Admissions for Non-Inpatient Services** – Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not Medically Necessary on an Inpatient basis.
2. **Administrative Charges** – Charges for any of the following:
   a. Failure to keep a scheduled visit.
   b. Completion of claim forms or medical records or reports unless otherwise required by law.
   c. For Physician or Hospital's stand-by services.
   d. For holiday or overtime rates.
   e. Membership, administrative, or access fees charged by Physicians other than Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
   f. Specific medical reports including those not directly related to the treatment of the Member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
3. **Allergy Services** – Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
4. **Alternative Therapies** – Hypnotherapy. Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to: holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy at a salon, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology (study of the iris). This exclusion also applies to recreational or educational sleep therapy or other forms of self-care or non-medical self-help training and any related diagnostic testing.
5. **Before Coverage Begins/After Coverage Ends** – Services rendered or supplies provided before coverage begins (i.e., before a Member's Effective Date) or after coverage ends.
6. **Biomicroscopy** – Biomicroscopy, field charting or aniseikonic investigation.
7. **Certain Providers** – Services You get from Provider that are not licensed by law to provide Covered Services as defined in this Benefit Booklet. Examples of non-covered Providers include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.
8. **Christian Science** practitioner services.
9. **Clinically Equivalent Alternatives** – Certain Prescription Drugs may not be covered if You could use a clinically equivalent Drug, unless required by law. 'Clinically equivalent" means Drugs that for most Members, will give You similar results for a disease or condition. If You have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of Your Identification Card, or visit the Claims Administrator's website at www.anthem.com. If You or Your Physician believes You need to use a different Prescription Drug, please have Your Physician or pharmacist get in touch with the Claims Administrator. The Plan will cover the other Prescription Drug only if agreed that it is Medically Necessary and appropriate over the clinically equivalent Drug. The Claims Administrator will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.
10. **Comfort and Convenience Items** – Personal comfort items such as those that are furnished primarily for Your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.
11. **Complications of/or Services Related to Non-Covered Services** – Services, supplies, or treatment related to or, for problems directly related to a service that is not covered by the Plan. Directly related means that the care took place as a direct result of the Non-Covered Service and would not have taken place without the Non-Covered Service.

12. **Compound Drugs** – Compound Drugs unless all of the ingredients are FDA-approved, and require a Prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a Drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
13. **Cosmetic Services** – Treatments, services, Prescription Drugs, equipment or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how You look or are given social reasons. No benefits are available for surgery or treatments to change the texture or look of Your skin or to change the size, shape or look of facial or body features (such as Your nose, eyes, ears, cheeks, chin, chest or breasts). This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy, surgery to correct birth defects and birth abnormalities, and services permitted under "Gender Affirming Surgery".
14. **Court-Ordered Services** – Court-ordered services, or those required by court order as a condition of parole or probation unless Medically Necessary and approved by the Plan.
15. **Crime and Incarceration** – Injuries received while committing a crime as well as care required while incarcerated in a Federal, state or local penal institution or required while in custody of Federal, state or local law enforcement authorities unless otherwise required by law or regulation. This Exclusion does not apply if Your involvement in the crime was solely the result of a medical or mental condition, or where You were the victim of a crime, including domestic violence.
16. **Custodial Care and Rest Care** – Custodial care, domiciliary care, rest cures, or travel expenses even if recommended for health reasons by a Physician. Inpatient room and board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change, Physical Therapy or treatment of chronic pain.
17. **Daily Room Charges** – Daily room charges while the Plan is paying for an intensive care, cardiac care or other special care unit.
18. **Dental Care** – Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered in this Benefit Booklet.
19. **Educational Services** – Educational services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunctions, learning disorders, behavioral training, and cognitive rehabilitation. This includes educational services, treatment or testing and training related to behavioral (conduct) problems, including but not limited to, services for conditions related to autistic disease of childhood (except to the same extent that the Plan provides for neurological disorders and applied behavioral analysis), hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning impairments, behavioral problems, and mental and intellectual impairment Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, is not covered.
20. **Excessive Expenses** – Expenses in excess of the Plan's Maximum Allowed Amount.
21. **Employer or Association Medical/Dental Department** – Received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trust or similar person or group.
22. **Experimental/Investigative Services** – Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the Claims Administrator's judgment, Experimental or Investigative for the diagnosis for which the Member is being treated. An Experimental or Investigative service is not made eligible for coverage by the fact that other treatment is considered by a Member's Physician to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.
23. **Family Members** – Services rendered by a Provider who is a close relative or member of Your household. Close relative means wife or husband, parent or grandparent, child, brother or sister, by blood, marriage (including in-laws) or adoption.

24. **Foot Care** – Foot care only to improve comfort or appearance, routine care of corns, bunions (except capsular or related surgery), calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for Members with impaired circulation to the lower extremities.
25. **Free Services** – Services and supplies for which You have no legal obligation to pay, or for which no charge has been made or would be made if You had no health insurance coverage.
26. **Government Programs** – Treatment where payment is made by a local, state, or Federal government (except Medicaid), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which You as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
27. **Hair** – Hair transplants, hair pieces or wigs (except when necessitated by disease) wig maintenance, or Prescriptions or medications related to hair growth.
28. **Health Spa** – Expenses incurred at a health spa or similar Facility.
29. **Ineligible Hospital** – Any services rendered or supplies provided while You are confined in an Ineligible Hospital.
30. **Ineligible Provider** – Any services rendered or supplies provided while You are a patient or receive services at or from an Ineligible Provider.
31. **Inpatient Rehabilitation Programs** – Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation Facility, when the Member is medically stable and does not require skilled nursing care or the constant availability of a Physician or:
    a. the treatment is for maintenance therapy; or
    b. the Member has no restorative potential; or
    c. the treatment is for congenital learning or neurological impairment/disorder; or
    d. the treatment is for communication training, educational training or vocational training.
32. **Maintenance Care** – Services which are solely performed to preserve the present level of function or prevent regression of functions for an illness, Injury or condition which is resolved or stable.
33. **Marital Counseling** – Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
34. **Medicare** – For which benefits are payable under Medicare Parts A and/or B or would have been payable if You had applied for Parts A and/or B, except as listed in this Benefit Booklet or as required by Federal law, as described in the section titled “Medicare” in **General Information**. If You do not enroll in Medicare Part B when You are eligible, you may have large Out-of-Pocket costs because coverage under this Plan becomes secondary. Your Employer is not responsible for advising You as to Your rights and responsibilities under Medicare. You remain solely responsible for Your decisions as to whether and when to enroll in Medicare. Please refer to Medicare.gov or contact Medicare for more details on when You should enroll, coordination of benefits with Medicare, and when You are allowed to delay enrollment without penalties. With respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor after the expiration of the 30 month coordination period whether or not the Participant has enrolled in Medicare Part B.
35. **Never Events** – the Plan will not pay for errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, which indicate a problem exists in the safety and credibility of a health care Facility. The Provider will be expected to absorb such costs. This Exclusion includes, but is not limited to, such errors as operating on the wrong side of the body, operating on the wrong part of the body, using the wrong procedure, or operating on the wrong patient.
36. **Non-Approved Drugs** – Drugs not approved by the FDA.
37. **Non-Approved Facility** - Services from a Provider that does not meet the definition of Facility.
38. **Non-Covered Services** – Any item, service, supply or care not specifically listed as a Covered Services in this Benefit Booklet.
39. **Not Medically Necessary Services** – Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness. This includes, but is not

limited to, care which does not meet the Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.

40. **Obesity Services** – Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or Prescription Drugs, or dietary control (except as related to covered nutritional counseling). Nutritional supplements, services, supplies and/or nutritional sustenance products (food) related to Enteral feeding except when it's the sole means of nutrition. Food supplements. Any services or supplies that involve weight reduction as the main method of treatment, including medical or counseling. Weight loss programs including, but not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, and LA Weight Loss), nutritional supplements, appetite suppressants, and supplies of a similar nature. This Exclusion does not apply to morbid obesity surgery when approved by the Plan.
41. **OIG Excluded Drugs** – Any service, Drug, Drug regimen, treatment, or supply, furnished, ordered, or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or state regulatory agencies. This exclusion does not apply to Emergency care.
42. **Over the Counter Drug Equivalents** – Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply may not be covered even written as a Prescription. This exclusion does not apply to over the counter products that the Plan must cover as a "Preventive Services" benefit under Federal law with a Prescription.
43. **Prescription Drugs Contrary to Approved Medical and Professional Standards** – Drugs given to You or prescribed in a way that is against approved medical and professional standards of practice.
44. **Prescription Drugs Over Quantity or Age Limits** – Drugs which are over any quantity or age limits set by the Plan.
45. **Prescription Drugs** - Outpatient prescription drugs prescribed by a Physician and purchased or obtained from a retail pharmacy or retail pharmacist or a mail service pharmacy are excluded. These may be covered by a separate drug card program but not under the Plan. Although coverage for outpatient Prescription Drugs obtained from a retail pharmacy or pharmacist or mail service Pharmacy is excluded, certain Prescription Drugs are covered under the Plan when rendered in a Hospital, in a Physician's office, or as part of a Home Health Care benefit. Therefore, this exclusion does not apply to prescription drugs provided as Ancillary Services during an Inpatient stay or an Outpatient Surgical procedure; to prescription drugs used in conjunction with a diagnostic service; Chemotherapy performed in the office; home infusion or home IV therapy, nor drugs administered in Your Physician's office. Contraceptive Drugs, except for any above stated covered contraceptive devices
46. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** – Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by the Plan.
47. **Private Rooms** – Private rooms, except as specified in Covered Services.
48. **Residential Accommodations** – Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This exclusion includes procedures, equipment, services, supplies or charges for the following:
    a. Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    b. Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home, or other extended care Facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar Facility or institution.
    c. Services or care provided or billed by a school, Custodial Care center for the developmentally impaired or outward bound programs, even if psychotherapy is included.
49. **Research Screenings** – For examinations related to research screenings, unless required by law.
50. **Reversal of Elective Sterilization** – Services related to or performed in conjunction with reverse elective sterilization.

51. **Routine Examinations** – Routine physical examinations, screening procedures, participation in school athletic programs, recreational camps or retreats or any insurance program which are not called for by known symptoms and illness or Injury except those which may be specifically listed as covered in this Benefit Booklet.
52. **Safe Surroundings** – Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.
53. **Sclerotherapy** – Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
54. **Services Not Specified as Covered** – No benefits are available for services that are not specifically described as Covered Services in this Benefit Booklet. This exclusion applies even if Your Physician orders the service.
55. **Sexual Dysfunction** – Medical/surgical services or supplies for treatment of male or female sexual or erectile dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction) regardless of origin or cause. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing. This exclusion does not apply to any benefits covered under "Gender Affirming Surgery".
56. **Shoes and Orthotics** – Shoe inserts, orthotics (except when prescribed by a Physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary), and orthopedic shoes (except when an orthopedic shoes is joined to a brace).
57. **Smoking cessation programs** - Services and supplies for smoking cessation programs and treatment of nicotine addiction, including gum, patches, and prescription drugs to eliminate or reduce the dependency on or addiction to tobacco and tobacco products unless otherwise required by law.
58. **Supplies or Equipment (Including Durable Medical Equipment) Not Medically Necessary)** – Supplies or equipment not Medically Necessary for the treatment of an Injury or illness. Non-covered supplies are inclusive of, but not limited to:
    a. Band-aids, tape, non-sterile gloves, thermometers, heating pads, hot water bottles, home enema equipment, sterile water and bed boards;
    b. household supplies, including, but not limited to, deluxe equipment, such as motor-driven chairs or bed, electric stair chairs or elevator chairs; ergonomically correct chairs;
    c. the purchase or rental of exercise cycles, physical fitness, exercise and massage equipment, ultraviolet/tanning equipment;
    d. water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools;
    e. escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Member's house or place of business and adjustments made to vehicles;
    f. air conditioners, humidifiers, dehumidifiers or purifiers;
    g. rental or purchase of equipment if You are in a Facility which provides such equipment;
    h. consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications; and,
    i. other items of equipment that the Claims Administrator determines do not meet the listed criteria.
    j. Masks except when used with Durable Medical Equipment.

    Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in Your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is Your responsibility.
59. **Temporomandibular Joint Disease** – Treatment for Temporomandibular Joint Disease (TMJ) including surgical and diagnostic services.

60. **Therapy Services** – Services for outpatient therapy or rehabilitation other than those specifically listed as covered in this Benefit Booklet. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, Rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, cognitive therapy, electromagnetic therapy, salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes which are performed as a treatment for acne.
61. **Transportation** – Transportation provided by other than a state licensed professional ambulance service, and Ambulance Services that are not Medically Necessary. Transportation to another area for medical care is also excluded except as stated as covered under the "Ambulance Service" section. Ambulance transportation from the Hospital to the home is not covered.
62. **Travel Costs and Mileage** – For mileage costs or other travel expenses, except as authorized by the Claims Administrator, on behalf of the Employer.
63. **Thermograms** – Thermograms and thermography.
64. **Tuition** for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.
65. **Vein Treatment -** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
66. **Vision Care** – Vision care services and supplies, including but not limited to, eyeglasses, contact lenses, and related examinations and services. Analysis of vision or the testing of its acuity except as otherwise indicated in this Benefit Booklet. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition i.e., diabetes.
67. **Vision Surgeries** – Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
68. **Vitamins**, minerals and food supplements, as well as vitamin injections not determined to be Medically Necessary in the treatment of a specific illness. Nutritional supplements, services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be Medically Necessary.
69. **Waived Cost Shares Out-of-Network** – For any service for which You are responsible under the terms of the Plan to pay a Coinsurance or Deductible, and the Coinsurance or Deductible is waived by an Out-of-Network Provider.
70. **Waived Fees** – Any portion of a Provider's fee or charge which is ordinarily due from a Member but which has been waived. If a Provider routinely waives (does not require the Member to pay) a Deductible or Out-of-Pocket amount, the Claims Administrator will calculate the actual Provider fee or charge by the amount waived.
71. **War/Military Duty** – Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military Facilities except as required by law.
72. **Wilderness Therapies** – Mental health treatment strategy also known as outdoor behavioral healthcare. Not excluded if provided by a licensed and accredited provider.
73. **Workers' Compensation** – Care for any condition or Injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law. If Workers' Compensation Act benefits are available to You, this this exclusion does not apply. This exclusion applies if You receive benefits in whole or in part. This exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party.

# CLAIMS PAYMENT

Network Providers have agreed to submit claims directly to the local Blue Cross and/or Blue Shield plan in their area. Therefore, if the Network Hospitals, Physicians, and ancillary Providers are used, claims for their services will generally not have to be filed by the Member. In addition, many Out-of-Network Hospitals and Physicians will also file claims if the information on the Blue Cross and Blue Shield Identification Card is provided to them. If the Provider requests a claim form to file a claim, a claim form can be obtained by contacting Accolade.

Please note You may be required to complete an authorization form in order to have Your claims and other personal information sent to the Claims Administrator when You receive care in foreign countries. Failure to submit such authorizations may prevent foreign Providers from sending Your claims and other personal information to the Claims Administrator.

## How to File Claims

Under normal conditions, the Claims Administrator should receive the proper claim form within **12** months after the service was provided. This section of the Benefit Booklet describes when to file a benefits claim and when a Hospital or Physician will file the claim for You.

Each person enrolled through the Plan receives an Identification Card. Remember, in order to receive full benefits, You must receive treatment from a Network Provider. When admitted to a Network Hospital, present Your Identification Card. Upon discharge, You will be billed only for those charges not covered by the Plan. **Residents of DC/Maryland/Northern Virginia, Florida, New Hampshire, and New Jersey must use POS Network Providers to receive Network benefits.**

When You receive Covered Services from a Network Physician or other Network licensed health care Provider, ask him or her to complete a claim form. Payment for Covered Services will be made directly to the Provider.

For health care expenses other than those billed by a Network Provider, use a claim form to report Your expenses. You may obtain these from Your Employer or Accolade. Claims should include Your name, Member identification number, Plan and Group numbers exactly as they appear on Your Identification Card. Attach all bills to the claim form and file directly with the Claims Administrator. Be sure to keep a photocopy of all forms and bills for Your records. The address is on the claim form.

Save all bills and statements related to Your illness or Injury. Make certain they are itemized to include dates, places, and nature of services or supplies.

## Maximum Allowed Amount

### General

This section describes how the Claims Administrator determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by Network and Out-of-Network Providers is based on the Plan's Maximum Allowed Amount for the Covered Service that You receive. Please refer to the "Inter-Plan Arrangements" section for additional information.

The Maximum Allowed Amount for the Plan is the maximum amount of reimbursement Anthem will allow for services and supplies:

- That meet the Plan's definition of Covered Services, to the extent such services and supplies are covered under The Plan and are not limited or excluded
- That are Medically Necessary
- That are provided in accordance with all applicable Preauthorization, Precertification, utilization management, or other requirements set forth in the Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. Except for Surprise Billing Claims*, if You receive Covered Services from an Out-of-Network Provider, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

*Surprise Billing Claims are described in the Consolidated Appropriations Act of 2021 Notice in the Health Benefits Coverage Under Federal Law . Please refer to that section for further details.

When You receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistently with procedure coding rules and/or reimbursement policies. For example, Your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Physician or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

**Provider Network Status**
The Maximum Allowed Amount may vary depending upon whether the Provider is a Network Provider or an Out-of-Network Provider.

A Network Provider is a Provider who is in the managed network for this specific service or in a special Center of Medical Excellence or other closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Services performed by a Network Provider, the Maximum Allowed Amount for the Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. Please call Accolade Member Services for help in finding a Network Provider or visit www.anthem.com.

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary Providers.

Except for Surprise Billing Claims, we will calculate the Maximum Allowed Amount for Covered Services You receive from an Out-of-Network Provider using one of the following:

1. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Provider's fees and costs to deliver care. When possible, professional claims will use the seventieth percentile of all charges for the particular service performed by a provider in the same or similar specialty and in the same geographical area, as reported in a benchmark database maintained by a non-profit organization; or
2. An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established at its discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
3. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, the Claims Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or
4. An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

5. An amount based on or derived from the total charges billed by the Out-of-Network Provider; or

6. An amount as required by applicable law.

Providers who are not contracted for this service, but contracted for other services with the Claims Administrator, are also considered Out-of-Network. For the Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount and except for Surprise Billing Claims.

For Covered Services rendered outside the Claims Administrator's Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating Provider fee schedule/rate or the pricing arrangements required by applicable state or Federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing the Plan would use if the healthcare services had been obtained within the Claims Administrator's Service Area, or a special negotiated price.

Unlike Network Providers, Out-of-Network Providers may send You a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount unless Your claim is a Surprise Billing Claim. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges except for Surprise Billing Claims. This amount can be significant. Choosing a Network Provider will likely result in lower Out-of-Pocket costs to You. Please call Accolade Member Services for help in finding a Network Provider or visit the Claims Administrator's website at www.anthem.com.

Accolade Member Services is also available to assist You in determining this Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for the Claims Administrator to assist You, You will need to obtain from Your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out-of-Pocket responsibility. Although Accolade Member Services can assist You with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted by the Provider.

**Member Cost Share**
For certain Covered Services and depending on the Plan design, You may be required to pay a part of the Maximum Allowed Amount as Your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether You received services from a Network or Out-of-Network Provider. Specifically, You may be required to pay higher cost sharing amounts or may have limits on Your benefits when using Out-of-Network Providers. Please refer to the Schedule of Benefits in this Benefit Booklet for Your cost share responsibilities and limitations, or call Accolade Member Services to learn how the Plan's benefits or cost share amounts may vary by the type of Provider You use.

The Plan will not provide any reimbursement for Non-Covered Services. You may be responsible for the total amount billed by Your Provider for Non-Covered Services, regardless of whether such services are performed by a Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of the Plan, as described in this Benefit Booklet, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

The Claims Administrator and/or its designated Pharmacy Benefits Manager may receive discounts, rebates, or other funds from Drug manufacturers, wholesalers, distributors, and/or similar vendors, which may be related to certain Prescription Drug purchases under the Plan and which positively impact the cost effectiveness of Covered Services. These amounts are retained by the Claims Administrator. These amounts will not be applied to Your Deductible, if any, or taken into account in determining Your Copayment or Coinsurance.

**Authorized Services**
In some circumstances, such as where there is no Network Provider available for the Covered Service within a radius of 30 miles from Member's home, the Plan may authorize the Network cost-share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out-of-Network Provider (this is referred to as "In-For-Out Benefit Treatment"). In such circumstance, You must contact Accolade in advance of obtaining the Covered Service in order to get approval for In-For-Out Benefit Treatment. The Plan will authorize the Network cost-share amounts to apply to a claim for Covered Services if You receive Emergency Services from an Out-of-Network Provider. If the Plan authorizes a Network cost-share amount for Non-Emergency Care for Covered Services provided by an Out-of-Network Provider, You also may still be liable for the difference

between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless Your claim is a Surprise Billing Claim.

Please contact Accolade for Authorized Services information or to request authorization.

## Services Performed During Same Session

The Plan may combine the reimbursement of Covered Services when more than one service is performed during the same session. Reimbursement is limited to the Plan's Maximum Allowed Amount. If services are performed by Out-of-Network Providers, then You are responsible for any amounts charged in excess of the Plan's Maximum Allowed Amount with or without a referral or regardless if allowed as an Authorized Service. Contact Accolade for more information.

## Processing Your Claim

You are responsible for submitting Your claims for expenses not normally billed by and payable to a Hospital or Physician. Always make certain You have Your Identification Card with You. Be sure Hospital or Physician's office personnel copy Your name, and identification numbers (including the 3-letter prefix) accurately when completing forms relating to Your coverage.

## Timeliness of Filing for Member Submitted Claims

To receive benefits, a properly completed claim form with any necessary reports and records must be filed by You within **12** months of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, You will be notified of the reason for the delay and will receive a list of all information needed to continue processing Your claim. After this data is received, the Claims Administrator will complete claims processing. No request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

## Necessary Information

In order to process Your claim, the Claims Administrator may need information from the Provider of the service. As a Member, You agree to authorize the Physician, Hospital, or other Provider to release necessary information.

The Claims Administrator will consider such information confidential. However, the Plan and the Claims Administrator have the right to use this information to defend or explain a denied claim.

## Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax, or other fee. If applicable, we will include any such surcharge, tax, or other fee as part of the claim charge passed on to You.

## Claims Review

The Claims Administrator has processes to review claims before and after payment to detect fraud, waste, abuse, and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balance billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

## Notice of Claim & Proof of Loss

After You get Covered Services, we must receive written notice of Your claim within **12 months** in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within **12 months** or no benefits will be covered, unless otherwise required by law (e.g., Federal law allows exceptions for claims filed by the Veteran's Administration up to a maximum 6 years from the date of service).

## Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If You fail to cooperate (including if You fail to enroll under Part B of the Medicare program where Medicare is the responsible payer), You will be responsible for any charge for services.

## Explanation of Benefits

After You receive medical care, You will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage You receive. The EOB is not a bill, but a statement sent by the Claims Administrator, to help You understand the coverage You are receiving. The EOB shows:

- total amounts charged for services/supplies received;
- the amount of the charges satisfied by Your coverage;
- the amount for which You are responsible (if any); and
- general information about Your appeals rights and for ERISA plans, information regarding the right to bring an action after the appeals process.

## Inter-Plan Arrangements

**Out-of-Area Services**

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever You access healthcare services outside the geographic area the Claims Administrator serves (the "**Anthem** Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside of the **Anthem** Service Area, You will receive it from one of two kinds of Providers. Most Providers ("participating Providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating Providers") don't contract with the Host Blue. Explained below is how both kinds of Providers are paid.

**Inter-Plan Arrangements Eligibility – Claim Types**

**F.** Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that You obtain from a Pharmacy and most dental or vision benefits.

**A. BlueCard® Program**

Under the BlueCard® Program, when You receive Covered Services within the geographic area served by a Host Blue, the Claims Administrator will still fulfill its contractual obligations. But, the Host Blue is responsible for (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When You receive Covered Services outside the **Anthem** Service Area and the claim is processed through the BlueCard® Program, the amount You pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to the Claims Administrator.

Often this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price the Plan used for Your claim because they will not be applied after a claim has already been paid.

**B. Negotiated (non-BlueCard Program) Arrangements**

With respect to one or more Host Blues, instead of using the BlueCard Program, **Anthem** may process Your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount You pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (please refer to the description of negotiated price under Section A. BlueCard Program) made available to **Anthem** by the Host Blue.

**C. Special Cases: Value-Based Programs**

*BlueCard® Program*
If You receive Covered Services under a Value-Based Program inside a Host Blue's Service Area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such arrangement, except when a Host Blue passes these fees to **Anthem** through average pricing or fee schedule adjustments. Additional information is available upon request by calling Accolade Member Services.

*Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements*
If **Anthem** has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Employer on Your behalf, **Anthem** will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

**D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees**
Federal or state laws or regulations may require a surcharge, tax, or other fee. If applicable, the Plan will include any such surcharge, tax, or other fee as part of the claim charge passed on to You.

**E. Nonparticipating Providers Outside the Claims Administrator's Service Area**

- The pricing method used for nonparticipating Provider claims incurred outside the **Anthem** Service Area is described in **Claims Payment**.

**F. Blue Cross Blue Shield Global Core® Program**

Foreign claims are covered at the In-Network benefit level for all medically necessary services when rendered outside of the country effective 4/20/2023. For services rendered Out-of-Network, You will pay 20% of the billed charge or Global Core contracted rate negotiated at time of service of Covered Services meeting Your Deductible. Prior to this date, foreign claims are covered for Emergency and Urgent care services only.

<table>
<tr><th>Benefit</th><th colspan="2">Higher Deductible HSA plan<br>Lower Deductible HSA plan</th><th>Copay PPO plan</th></tr>
<tr><td>All Services, including emergency hospitalizations.</td><td colspan="2">Network Provider: You pay 20% of the Global Core contracted rate of covered Services after meeting Your Deductible. You may be responsible for paying up to Your in-Network Out-of-Pocket Max when discharged.<br><br>Out of Network Provider: You will be responsible for the entirety of billed charges or Global Core contracted rate* when discharged and can later submit reimbursement to Global Core.<br><br>You pay 20% of the billed charge or Global Core contracted rate negotiated at time of service*, of Covered Services after meeting Your Deductible.<br><br>* You or someone traveling with You will need to contact Global Core who will attempt to negotiate a discounted rate at the time of the service.</td><td>Network Provider: You pay 20% of the Global Core contracted rate or Copay of covered Services after meeting the Deductible. You may be responsible for paying up to Your in-Network Out-of-Pocket Max when discharged.<br><br>Out of Network Provider: You will be responsible for the entirety of billed charges or Global Core contracted rate* when discharged and can later submit reimbursement to Global Core.<br><br>You pay 20% of the Billed Charge or Global Core contracted rate negotiated at time of service*, of Covered Services after meeting Your Deductible.<br><br>* You or someone traveling with You will need to contact Global Core who will attempt to negotiate a discounted rate at the time of the service.</td></tr>
<tr><td colspan="4">For any overpayments to the Provider, please call Accolade to assist You in working with the Provider on reimbursement.</td></tr>
</table>

If You plan to travel outside the United States, call Accolade Member Services to find out Your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take Your current Identification Card with You. You can also view your identification card on the Sydney Mobile App.

When You are traveling abroad and need medical care, You can call the Blue Cross Blue Shield Global Core® Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or You can call them collect at 804-673-1177.

If You need Inpatient hospital care, You or someone on Your behalf, should contact **Accolade** for Preauthorization. Keep in mind, if You need Emergency medical care, go to the nearest Hospital. There is no need to call before You receive care.

Please refer to the **Health Care Management – Precertification** section in this Booklet for further information. You can learn how to get Preauthorization when You need to be admitted to the Hospital for emergency or non-Emergency care.

**How Claims are Paid with Blue Cross Blue Shield Global Core®**
In most cases, when You arrange Inpatient hospital care with Blue Cross Blue Shield Global Core®, claims will be filed for You. The only amounts that You may need to pay up front are Copayment, Coinsurance, or Deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Physician services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core®; and
- Outpatient services.

You will find the address for mailing the claim on the form.

When You need Blue Cross Blue Shield Global Core® claim forms, You can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core® Service Center at the numbe
- rs above; or
- Online at www.bcbsglobalcore.com

You will find the address for mailing the claim on the form.

## Unauthorized Use of Identification Card

If You permit Your Identification Card to be used by someone else or if You use the card before coverage is in effect or after coverage has ended, You will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage. Fraudulent statements on enrollment forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the Member's coverage. This includes fraudulent acts to obtain medical services and/or Prescription Drugs.

## Assignment

You authorize the Claims Administrator, in its own discretion and on behalf of the Employer, to make payments directly to Providers for Covered Services. In no event, however, shall the Plan's right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. The Claims Administrator also reserves the right, in its own discretion, to make payments directly to You as opposed to any Provider for Covered Service. In the event that payment is made directly to You, You have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the Plan), or that person's custodial parent or designated representative. Any payments made by the Claims Administrator (whether to any Provider for Covered Service or You) will discharge the Employer's obligation to pay for Covered Services. You cannot assign Your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law.

The coverage, rights, and benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the Plan and/or law, sue or otherwise begin legal action, or request Plan documents or any other information that a Participant or beneficiary may request under ERISA, if subject to ERISA. Any assignment made without written consent from the Plan will be void and unenforceable.

## Questions About Coverage or Claims

If You have questions about Your coverage, contact Accolade Member Services.

**When asking about a claim, Accolade may request the following information:**

- Identification number;
- Patient's name and address;
- Date of service and type of service received; and
- Provider name and address (Hospital or Physician).

To find out if a Hospital or Physician is a Network Provider, call them directly or call Accolade.

The Plan does not supply You with a Hospital or Physician. In addition, neither the Plan nor the Claims Administrator is responsible for any Injuries or damages You may suffer due to actions of any Hospital, Physician, or other person. In order to process Your claims, the Claims Administrator or the Plan Administrator may request additional information about the medical treatment You received and/or other group health insurance You may have. This information will be treated confidentially.

An oral explanation of, or representations regarding, Your benefits by an employee of the Claims Administrator, Plan Administrator, or Plan Sponsor is not legally binding.

Any correspondence mailed to You will be sent to Your most current address on file with the Plan Administrator. You are responsible for notifying the Plan Administrator of any changes to Your address.

# YOUR RIGHT TO APPEAL

The Plan wants Your experience to be as positive as possible. There may be times, however, when You have a complaint, problem, or question about the Plan or a service You have received. In those cases, please contact Accolade by calling the number on the back of Your Identification Card. The Claims Administrator will try to resolve Your complaint informally by talking to Your Provider or reviewing Your claim. If You are not satisfied with the resolution of Your complaint, You have the right to file an appeal, which is defined as follows:

For purposes of these appeal provisions, "claim for benefits" means a request for benefits under the Plan. The term includes both pre-service and post-service claims.

- A pre-service claim for benefits under the Plan for which You have not received the benefit or for which You may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the Plan for which You have received the service.

If Your claim is denied or if Your coverage is rescinded:

- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

The procedure the Claims Administrator will follow will satisfy the requirements for a full and fair review under applicable Federal regulations.

**Notice of Adverse Benefit Determination**
If Your claim is denied, the Claims Administrator's notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the Claims Administrator's determination is based;
- a description of any additional material or information needed to perfect Your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan's review procedures and the time limits that apply to them, including a statement of Your right to bring a civil action under Section 502 of ERISA, if the Plan is subject to ERISA, within one year of the appeal decision if You submit an appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about Your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination based on Medical Necessity or experimental treatment, or about Your right to request this explanation free of charge, along with a discussion of the claims denial decision; and,
- information regarding Your potential right to an External Appeal pursuant to Federal law.

For claims involving urgent/concurrent care:

- the Claims Administrator's notice will also include a description of the applicable urgent/concurrent review process; and
- the Claims Administrator may notify You or Your authorized representative within 72 hours orally and then furnish a written notification.

**Appeals**
You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or Your authorized representative must file Your appeal within 180 calendar days after You are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting Your claim. The Claims Administrator's review of Your claim will take into account all information You submit, regardless of whether it was submitted or considered in the initial benefit determination.

The Claims Administrator shall offer a mandatory first level of appeal and an additional mandatory second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g., pre-service, concurrent, post-service, urgent, etc.).

**For pre-service claims involving urgent/concurrent care,** You may obtain an expedited appeal. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile, or other similar method. To file an appeal for a claim involving urgent/concurrent care, You or Your authorized representative must contact Accolade at the number shown on Your Identification Card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought, and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g., Urgent Care). You or Your authorized representative must submit a request for review to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals PO Box 105568 Atlanta GA 30348

**You must include Your Member identification number when submitting an appeal.**

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the Plan, applied consistently for similarly situated claimants; or
- is a statement of the Plan's policy or guidance about the treatment or benefit relative to Your diagnosis.

The Claims Administrator will also provide You, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with Your claim. In addition, before You receive an adverse benefit determination or review based on a new or additional rationale, the Claims Administrator will provide You, free of charge, with the rationale.

**For Out of State Appeals** You have to file Provider appeals with the Host Plan. This means Providers must file appeals with the same Plan to which the claim was filed.

**How Your Appeal will be Decided**

When the Claims Administrator considers Your appeal, the Claims Administrator will not rely upon the initial benefit determination or, for mandatory second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A mandatory second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not Medically Necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care

professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

**Notification of the Outcome of the Appeal**
**If You appeal a claim involving urgent/concurrent care**, the Claims Administrator will notify You of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of Your request for appeal.

**If You appeal any other pre-service claim**, the Claims Administrator will notify You of the outcome of the appeal within 15 days after receipt of Your request for appeal.

**If You appeal a post-service claim**, the Claims Administrator will notify You of the outcome of the appeal within 30 days after receipt of Your request for appeal.

**Appeal Denial**
If Your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Claims Administrator will include all of the information set forth in the above section entitled "Notice of Adverse Benefit Determination."

If, after the Plan's initial claim denial, the Claims Administrator considers, relies on, or generates any new or additional evidence in connection with Your claim, the Claims Administrator will provide You with that new or additional evidence, free of charge. The Claims Administrator will not base its appeal decision on a new or additional rationale without first providing You (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If the Claims Administrator fails to follow the Appeal procedures outlined under this section the Appeals process may be deemed exhausted. However, the Appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond the Claims Administrator's control.

**Mandatory Second Level Appeals**
If You are dissatisfied with the Plan's mandatory first level appeal decision, a Mandatory second level appeal is available. If You would like to initiate a second level appeal, please write to the address listed above. Mandatory appeals must be submitted within 60 calendar days of the denial of the first level appeal.

**External Review**
If the outcome of the mandatory first level appeal is adverse to You and it was based on medical judgment, or if it pertained to a rescission of coverage, You may be eligible for an independent External Review pursuant to Federal law.

You must submit Your request for External Review to the Claims Administrator within four (4) months of the notice of Your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that You submitted for internal appeal. However, You are encouraged to submit any additional information that You think is important for review.

For pre-service claims involving urgent/concurrent care, You may proceed with an expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Claims Administrator's internal appeal process. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile, or other similar method. To proceed with an expedited External Review, You or Your authorized representative must contact Accolade at the number shown on Your Identification Card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

For Surprise Billing Claims, if Your claim for the date of service starting 01/01/2022 and after is not paid in full and is related to Emergency Services or Air Ambulance Services from an Out-of-Network Provider, or Covered Services from an Out-of-Network Provider at a Network Facility, and You believe the Claims Administrator priced those claims as Out-of-Network Benefits, You have the right to request an external review by an Independent Review Organization. If eligible for an independent external review, there is no cost to You. You have four months from the date You receive the appeal denial letter to ask for an independent external review. Your request must be in writing to the following address: Anthem Blue Cross and Blue Shield, ATTN: Appeals PO Box 105568 Atlanta GA 30348

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by You or Your authorized representative to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348

**You must include Your Member identification number when submitting an appeal.**

This is not an additional step that You must take in order to fulfill Your appeal procedure obligations described above. Your decision to seek External Review will not affect Your rights to any other benefits under the Plan. There is no charge for You to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA, if the Plan is subject to ERISA.

**Requirement to file an Appeal before filing a lawsuit.**
No lawsuit or legal action of any kind related to a benefit decision may be filed by You in a court of law or in any other forum, unless it is commenced within one year of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal appeals procedure, before filing a lawsuit, or taking other legal action of any kind against the Plan. If Your appeal as described above results in an adverse benefit determination, You have a right to bring a civil action under Section 502(a) of ERISA within one year of appeal decision.

**The Claims Administrator reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.**

# COORDINATION OF BENEFITS (COB)

This Coordination of Benefits (COB) provision applies when You have health care coverage under more than one COB Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Benefit Booklet, e.g., Plan. For this provision only, "This Plan" will have the meanings as specified below. In the rest of the Benefit Booklet, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determine the order in which each COB Plan will pay a claim for benefits. The COB Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another COB Plan may cover some expenses. The COB Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all COB Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill You for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than This Plan's Maximum Allowed Amount.

## COB Definitions

**COB Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same COB Plan and there is no COB among those separate contracts.

1. COB Plan includes Group and non-group insurance contracts and subscriber contracts; Health Maintenance Organization (HMO) contracts; uninsured arrangements of group or group-type coverage; coverage under group or non-group closed panel plans; group-type contracts; medical care components of long term care contracts such as skilled nursing care, medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); other governmental benefits, except for Medicaid or government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.
2. COB Plan does not include: Accident only coverage; specified disease or specified accident coverage; limited health benefit coverage; benefits for non-medical components of long term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; school accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for Coverage under items 1. or 2. above is a separate COB Plan. If a COB Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate COB Plan.

**This Plan** means the part of the contract providing health care benefits that the COB provision applies to and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determines whether this Plan is a Primary Plan or Secondary Plan when You have health care coverage under more than one COB Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other COB Plan without considering any other COB Plan's benefits. When This Plan is secondary, it determines its benefits after those of another COB Plan and may reduce the benefits it pays so that all COB Plan benefits do not exceed 100% of the total Allowable expense.

**Allowable expense** is a health care expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any COB Plan covering You. When a COB Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any COB Plan covering You is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non-Allowable expenses:

1. The difference between the cost of a Semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the COB Plans provides coverage for private Hospital room expenses.
2. If You are covered by 2 or more COB Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If You are covered by 2 or more COB Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If You are covered by one COB Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another COB Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all COB Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because You have failed to comply with the COB Plan provisions is not an Allowable expense. Examples of these types of COB Plan provisions include second surgical opinions, Precertification of admissions or services, and Network Provider arrangements.
6. The amount that is subject to the Primary high Deductible health plan's Deductible, if the Claims Administrator has been advised by You that all COB Plans covering You are high Deductible health plans and You intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

**Closed panel plan** is a COB Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the COB Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

**Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

## Order of Benefit Determination Rules

When You are covered by two or more COB Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other COB Plan.

1. Except as provided in Paragraph 2. below, a COB Plan that does not contain a Coordination of Benefits provision that is consistent with this COB provision is always primary unless the provisions of both COB Plans state that the complying COB Plan is primary.
2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the COB Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide Out-of-Network benefits.

A COB Plan may consider the benefits paid or provided by another COB Plan in calculating payment of its benefits only when it is secondary to that other COB Plan.

Each COB Plan determines its order of benefits using the first of the following rules that apply:

**Rule 1 – Non-Dependent or Dependent.** The COB Plan that covers You other than as a Dependent, for example as an Employee, Member, policyholder, subscriber, or retiree is the Primary Plan, and the COB Plan that covers You as a Dependent is the Secondary Plan. However, if You are a Medicare beneficiary and, as a result of Federal law, Medicare is secondary to the COB Plan covering You as a Dependent and primary to the COB Plan covering You as other than a Dependent (e.g., a retired employee), then the order of benefits between the two COB Plans is reversed so that the COB Plan covering You as an Employee, Member, policyholder, subscriber, or retiree is the Secondary Plan and the other COB Plan covering You as a Dependent is the Primary Plan.

**Rule 2 – Dependent Child Covered Under More Than One COB Plan.** Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one COB Plan the order of benefits is determined as follows:

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

- the COB Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
- if both parents have the same birthday, the COB Plan that has covered the parent the longest is the Primary Plan.

2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

- If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that COB Plan is primary. This rule applies to COB Plan years commencing after the COB Plan is given notice of the court decree;
- If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
- If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
  - the COB Plan covering the custodial parent;
  - the COB Plan covering the Spouse of the custodial parent;
  - the COB Plan covering the non-custodial parent; and then,
  - the COB Plan covering the Spouse of the non-custodial parent.

3. For a Dependent child covered under more than one COB Plan of individuals who are not the parents of the child, the provisions of items 1. or 2. above will determine the order of benefits as if those individuals were the parents of the child.
4. For a Dependent child who has coverage under either or both parents' COB Plans and also has his or her own coverage as a dependent under a Spouse's COB Plan, Rule 5 applies. In the event the Dependent child's coverage under the Spouse's COB Plan began on the same date as the Dependent child's coverage under either or both parents' COB Plans, the order of benefits will be determined by applying the birthday rule in item 1. above to the Dependent child's parent(s) and the Dependent's Spouse.

**Rule 3 – Active Employee or Retired or Laid-off Employee.** The COB Plan that covers You as an active Employee, that is, an Employee who is neither laid-off nor retired, is the Primary Plan. The COB Plan also covering You as a retired or laid-off Employee is the Secondary Plan. The same would hold true if You are a Dependent of an active Employee and You are a Dependent of a retired or laid-off Employee. If the other COB Plan does not have this rule, and as a result, the COB Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 – Non-Dependent or Dependent" can determine the order of benefits.

**Rule 4 – COBRA.** If You are covered under COBRA or under a right of continuation provided by other Federal law and are covered under another COB Plan, the COB Plan covering You as an Employee, Member, subscriber, or retiree, or covering You as a Dependent of an Employee, Member, subscriber, or retiree is the Primary Plan and the COBRA or other Federal continuation coverage is the Secondary Plan. If the other COB Plan does not have this rule, and as a result, the COB Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 – Non-Dependent or Dependent" can determine the order of benefits. This rule does not apply when the person is covered either: (a) as a non-Dependent under both COB Plans (i.e., the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the Group Health Plan as an Employee or as a retired Employee and is covered under his or her own COB Plan as an Employee, Member, subscriber, or retiree); or (b) as a Dependent under both COB Plans (i.e., the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the Group Health Plan as Dependent of an Employee Member or, Member, subscriber, or retired Employee and is covered under the other COB Plan as a Dependent of an Employee, Member, subscriber, or retiree).

**Rule 5 – Longer or Shorter Length of Coverage.** The COB Plan that covered You longer is the Primary Plan and the Plan that covered You the shorter period of time is the Secondary Plan.

**Rule 6** – If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the COB Plans meeting the definition of COB Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

## Secondary to Other Coverage

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy, or personal Injury protection policy regardless of any election made by anyone to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. This provision applies notwithstanding any Coordination of Benefits term to the contrary.

## Effect on the Benefits of this Plan

When This Plan is secondary, it will first calculate the benefits it would have paid in the absence of other health care coverage. If this amount is equal or less than the amount paid by the primary plan, this Secondary Plan will pay zero. Otherwise, the Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all COB Plans for the claim do not exceed the total Allowable expense for that claim.

## Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other COB Plans. The Claims Administrator may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other COB Plans covering the person claiming benefits. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Claims Administrator any facts the Claims Administrator needs to apply those rules and determine benefits payable.

## Facility of Payment

A payment made under another COB Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

## Right of Recovery

If the amount of the payments made by This Plan is more than should have paid under this COB provision, This Plan may recover the excess from one or more of the persons:

1. This Plan has paid or for whom This Plan have paid; or
2. any other person or organization that may be responsible for the benefits or services provided for the Member.

The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

## When a Covered Person Qualifies for Medicare

**Determining Which Plan is Primary**
To the extent permitted by law, This Plan will pay benefits second to Medicare when You become eligible for Medicare, even if You don’t enroll in Medicare. There are, however, Medicare-eligible individuals for whom the Plan pays benefits first and Medicare pays benefits second:

- Subscribers with active current employment status age 65 or older, or their Spouses age 65 or older, and
- individuals with end-stage renal disease, for a limited period of time.

Important information for Employees who cover a Medicare eligible Qualified Domestic Partner:

Your Qualified Domestic Partner must enroll in Medicare as soon as they are eligible to avoid late enrollment penalties or surcharges imposed on late enrollees in Medicare. **Once Your Qualified Domestic Partner is eligible for Medicare (even if Your Qualified Domestic Partner does not enroll in Medicare), Medicare is primary for your Qualified Domestic Partner and pays first even if You are actively working for your Employer and Your Qualified Domestic Partner is covered under This Plan as an eligible Dependent.**

**Determining the Allowable Expense When This Plan is Secondary to Medicare**
If This Plan is secondary to Medicare, the Medicare approved amount is the Allowable expense, as long as the Provider accepts Medicare. If the Provider does not accept Medicare, the Medicare limiting charge (the most a Provider can charge You if they don’t accept Medicare) will be the Allowable expense. Medicare payments, combined with This Plan’s benefits, will not exceed 100% of the total Allowable expense.

If You are eligible for, but not enrolled in, Medicare, and This Plan is secondary to Medicare as described above, benefits payable under this Plan will be reduced by the amount that would have been paid if You had been enrolled in Medicare.

The Plan is not responsible for keeping track of your Medicare status. The responsibility is on the Subscriber and Domestic Partner to ensure meeting Medicare requirements. You can be at risk for significant out of pocket costs if you do not enroll in Medicare as soon as you are eligible.

# SUBROGATION AND REIMBURSEMENT

Please refer to The Bank of New York Mellon Health and Welfare Plan and Summary Plan Description (as may be amended from time to time), which can be obtained from the Plan Administrator, for the Plan's subrogation and reimbursement requirements. You can also access it through the MyBenefit Solutions website:

- **At Work:** Single sign-on access through People Rewards (MySource > People > People Rewards > My External Links > Health > MyBenefit Solutions > Plan Documents > Health and Welfare Summary Plan Description)
- **At Home:** Visit MyBenefit Solutions at mybenefits.bnymellon.com. (If you're a new employee or haven't already registered, you'll need to create a username and password.)

# GENERAL INFORMATION

## Form or Content of Benefit Booklet

No agent or employee of the Claims Administrator is authorized to change the form or content of this Benefit Booklet. Such changes can be made only through an endorsement authorized and signed by an officer of the Employer.

## Protected Health Information under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer's Group Health Plan has a responsibility under the HIPAA Privacy Regulations to provide You with a Notice of Privacy Practices. This notice sets forth the Employer's rules regarding the disclosure of Your information and details about a number of individual rights You have under the Privacy Regulations. As the Claims Administrator of the Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If You would like a copy of Anthem's Notice, contact Accolade at the number on Your Identification Card.

## Workers' Compensation

The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Workers' Compensation Law. All sums paid or payable by Workers' Compensation for services provided to a Member shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation or equivalent Employer liability or indemnification law.

## Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payer, the benefits under the Plan shall not duplicate any benefits to which Members are entitled, or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, any duplicated benefit paid by the Plan shall be reimbursed by or on behalf of the Member to the Plan.

## Medicare

Any benefits covered under both the Plan and Medicare will be covered according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to Federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and Federal law.

Except when Federal law requires the Plan to be the primary payer, the benefits under the Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to You shall be reimbursed by or on Your behalf to us, to the extent we have made payment for such services. Your Employer is not responsible for advising You as to your rights and responsibilities under Medicare. You are solely responsible for Your decision as to whether and when to enroll in Medicare. If You do not enroll in Medicare Part B when You are eligible, You may have large out-of-pocket costs. Please refer to Medicare.gov or contact Medicare for more details on when You should enroll, coordination of benefits with Medicare and when You are allowed to delay enrollment without penalties.

## Right of Recovery and Adjustment

Whenever payment has been made in error, the Plan will have the right to recover such payment from You or, if applicable, the Provider or otherwise make appropriate adjustment to claims. In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

The Claims Administrator has oversight responsibility for compliance with Provider and vendor contracts. The Claims Administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, the Claims Administrator has established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. The Claims Administrator will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount. The Claims Administrator reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

## Relationship of Parties (Employer – Member - Claims Administrator)
Neither the Employer nor any Member is the agent or representative of the Claims Administrator.

## Relationship of Parties (Claims Administrator – Network Providers)
The relationship between the Claims Administrator and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Claims Administrator, nor is the Claims Administrator, or any employee of the Claims Administrator, an employee or agent of Network Providers.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Out-of-Network Providers, and disease management programs. If You have questions regarding such incentives or risk sharing relationships, please contact Your Provider or Accolade.

## Claims Administrator Note
The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield Plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of the Administrative Services Agreement or this Benefit Booklet.

## Notice
Any notice given under the Plan shall be in writing. The notices shall be sent to: The Employer at its principal place of business: The Bank of New York Mellon Corporation, 240 Greenwich Street, 19th Floor (101-1950), New York, NY 10286 and/or to You at the Subscriber's address as it appears on the records or in care of the Employer.

## Modifications or Changes in Coverage
The Plan Sponsor may change the benefits described in this Benefit Booklet and the Member will be informed of such changes as required by law. This Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Employer, or by mutual agreement between the Claims Administrator and the Employer without the consent or concurrence of any Member. By electing medical and Hospital benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

## Fraud
Fraudulent statements on Plan enrollment forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Member's coverage.

## Conformity with Law
Any provision of the Plan which is in conflict with the applicable Federal laws and regulations is hereby amended to conform with the minimum requirements of such laws.

## Clerical Error
Clerical error, whether of the Claims Administrator or the Employer, in keeping any record pertaining to coverage under the Plan will not invalidate coverage otherwise validly in force or continue benefits otherwise validly terminated.

## Policies, Procedures, and Pilot Programs
The Claims Administrator, on behalf of the Employer, may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan with which a Member shall comply.

Under the terms of the Administrative Service Agreement with Your Employer, the Claims Administrator has the authority, at its discretion, to institute from time to time, utilization management, care management, disease management, or wellness pilot initiatives in certain designated geographic areas. These pilot initiatives are part of the Claims Administrator's ongoing effort to find innovative ways to make available high quality and more affordable healthcare. A pilot initiative may affect some, but not all Members under the Plan. These programs will not result in the payment of benefits which are not provided in the Employer's Group Health Plan, unless otherwise agreed to by the Employer. The Claims Administrator reserves the right to discontinue a pilot initiative at any time without advance notice to the Employer.

## Value-Added Programs

The Claims Administrator may offer health or fitness related programs to Members, through which You may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits. As such, program features are not guaranteed under Your Employer's Group Health Plan and could be discontinued at any time. Neither the Plan Sponsor nor the Claims Administrator endorse any vendor, product, or service associated with this program. Program vendors are solely responsible for the products and services You receive.

## Waiver

No agent or other person, except an authorized officer of the Employer, has authority to waive any conditions or restrictions of the Plan, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

## Employer's Sole Discretion

The Employer may, in its sole discretion, from time to time, waive, enhance, change or end certain medical management processes and/or offer an alternate benefit if the Employer, with advice from the Claims Administrator, determines such change furthers the provision of cost effective, value based and/or quality services. In addition, the Employer may cover services and supplies not specifically covered by the Plan.

## Reservation of Discretionary Authority

The Claims Administrator shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of this Benefit Booklet as it relates to the Member. This includes, without limitation, the power to construe this Benefit Booklet, to determine all questions regarding benefits arising under the Plan with respect to this Benefits Booklet, to resolve Member appeals and to make, establish, and amend the rules, regulations, and procedures with regard to the interpretation of this Benefit Booklet. A specific limitation or exclusion will override more general benefit language. The Claims Administrator's determination shall be final and conclusive on the Member and may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowed Amount. A Member may utilize all applicable appeals procedures.

## Medical Policy and Technology Assessment

The Claims Administrator reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/Investigational status or Medical Necessity of new technology. Guidance and external validation of the Claims Administrator's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Physicians from various medical specialties, including the Claims Administrator's medical directors, Physicians in academic medicine, and Physicians in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply, or equipment is covered.

## Care Coordination

The Plan pays Network Providers in various ways to provide Covered Services to You. For example, sometimes the Plan may pay Network Providers a separate amount for each Covered Service they provide. The Plan may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, the Plan may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, the Plan may pay Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate Network Providers for coordination of Member care. In some instances, Network Providers may be required to make payment to the Plan because they did not meet certain standards. You do not share in any payments made by Network Providers to the Plan under these programs.

## Confidentiality and Release of Information

Applicable state and Federal law requires us to undertake efforts to safeguard Your medical information.

For informational purposes only, please be advised that a statement describing our policies and procedures regarding the protection, use, and disclosure of Your medical information is available on our website and can be furnished to You upon request by contacting Accolade.

# WHEN COVERAGE TERMINATES

Please refer to The Bank of New York Mellon Health and Welfare Plan and Summary Plan Description (as may be amended from time to time), which can be obtained from the Plan Administrator, for a summary of when coverage under the Plan terminates. You can also access it through the MyBenefit Solutions website:

- **At Work:** Single sign-on access through People Rewards (MySource > People > People Rewards > My External Links > Health > MyBenefit Solutions > Plan Documents > Health and Welfare Summary Plan Description)
- **At Home:** Visit MyBenefit Solutions at mybenefits.bnymellon.com. (If you're a new employee or haven't already registered, you'll need to create a username and password.)

# DEFINITIONS

## Accidental Injury
Bodily Injury sustained by a Member as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity, or any other cause) for care which the Member receives. Such care must occur while the Plan is in force. It does not include injuries for which benefits are provided under any Workers' Compensation, Employer's liability, or similar law.

## Administrative Services Agreement
The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the Plan. If there is any conflict between either this Benefit Booklet, or the Administrative Services Agreement and any amendment or rider to this Benefit Booklet or the Administrative Services Agreement, as the case may be, the amendment or rider shall control. If there is any conflict between this Benefit Booklet and the Administrative Services Agreement, the Administrative Services Agreement shall control.

## Ambulance Services
A state-licensed emergency vehicle which carries injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

## Anthem Blue Cross and Blue Shield
See page 2

## Authorized Service(s)
A Covered Service rendered by any Out-of-Network Provider, which has been authorized in advance (except for Emergency Care) by the Claims Administrator will be paid at the Network level. The Member may be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any applicable Network Coinsurance, Copayment, or Deductible unless Your claim is a Surprise Billing Claim. For more information, please refer to the **Claims Payment** section as well as the **Consolidated Appropriations Act of 2021 Notice** in the **Health Benefits Coverage Under Federal Law** section.

## Autism Spectrum Disorder (ASD) Program
See page 46.

## Benefit Period
One year, January 1 – December 31 (also called year or the calendar year). It does not begin before a Member's Effective Date. It does not continue after a Member's coverage ends.

## BlueCard® Program
See page 85.

## BlueCard Provider
A BlueCard Provider is part of the Blue Cross Blue Shield Association (the Association) program that links participating health care providers and independent Blue plans across the country with a single electronic network for claims processing and reimbursement. The Association is a group of independent, locally operated Blue Cross and Blue Shield plans.

Participation in BlueCard is a membership requirement for all Blue plans; the Association provides program oversight and administration.

## Blue Cross Blue Shield Global Core® Program
See page 86.

## Blue Distinction Surgery Providers

**Blue Distinction Center (BDC) Facility:** Blue Distinction Facilities have met or exceeded national quality standards for care delivery (quality only).

**Blue Distinction Center+ (BDC+) Facility:** Blue Distinction+ Facilities have met or exceeded national quality standards for care delivery AND have demonstrated that they operate more efficiently (quality and cost).

**Designated Surgery Provider:** A Provider who has achieved designation as a Blue Distinction Center+ or Blue Distinction Center for Surgery Procedures.

**PAR Surgery Provider:** Hospitals participating in the Claims Administrator's networks; also known as "Network" Provider or "PAR" (are NOT designated as either Blue Distinction Center+ or Blue Distinction Center).

**Non-PAR Surgery Provider:** Any Provider that does not hold a contractual agreement with Blue Cross Blue Shield plans to provide Surgery services; also known as "Out-of-Network" or "non-PAR".

## Centers of Medical Excellence (CME) Network

A network of health care Facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein Members access select types of benefits through a specific network of medical centers.

A network of health care professionals contracted with the Claims Administrator or one or more of its affiliates, to provide transplant or other designated specialty services.

## Claims Administrator

The company the Plan Sponsor chose to administer its medical benefits. Anthem, e.g., Anthem Insurance Companies, Inc. (IN) was chosen to administer the Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

## COB Plan

See Page 92.

## Code

The Internal Revenue Code of 1986, as amended, and the regulations thereunder.

## Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after You meet Your Deductible. For example, if the Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is $100, Your Coinsurance would be $20 after You meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the **Schedule of Benefits** for details.

## Combined Limit

The maximum total of Network and Out-of-Network benefits available for designated health services in the applicable **Schedule of Benefits**.

## Complications of Pregnancy

Complications of Pregnancy result from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy which is terminated is also considered a Complication of Pregnancy.

Complications of Pregnancy shall not include false labor, caesarean section, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as Complications of Pregnancy.

## Continued Stay/Concurrent Review

See Page 51.

## Congenital Anomaly

A condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

## Consolidated Appropriations Act of 2021

Please refer to the “Consolidated Appropriations Act of 2021 Notice” in the Health Benefits Coverage Under Federal Law section for details.

## Coordination of Benefits

A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental, or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

## Copayment

A cost-sharing arrangement in which a Member pays a specified charge for a Covered Service, such as the Copayment indicated in the **Schedule of Benefits** for an office visit. The Member is usually responsible for payment of the Copayment at the time the health care is rendered. Copayments are distinguished from Coinsurance as flat dollar amounts rather than percentages of the charges for services rendered and are typically collected by the Provider when services are rendered.

## Cosmetic Surgery

Any non-Medically Necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance, or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to: rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery. Please refer to “Gender Affirming Surgery” in the **Benefits** section for additional coverage in Cosmetic Surgery.

## Covered Dependent

Any Dependent in a Subscriber’s family who meets all the requirements of the **Eligibility** section of this Benefit Booklet, has enrolled in the Plan, and is subject to administrative service fee requirements set forth by the Plan.

## Covered Services

Medically Necessary health care services and supplies that are: (a) defined as Covered Services in the Member’s Plan, (b) not excluded under such Plan; (c) not Experimental/Investigative and (d) provided in accordance with such Plan.

## Covered Transplant Procedure

Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by the Claims Administrator, including necessary acquisition procedures, collection and storage, and including Medically Necessary preparatory myeloablative therapy.

## Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member’s activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care, including educational services, rest care, and convalescent care.

## Deductible

The portion of the bill You must pay before Your medical expenses become Covered Services. It is applied on a Calendar Year basis.

## Dependent

The Spouse or Qualified Domestic Partner and all children until attaining age limit stated in the **Eligibility** section. Children include natural children, legally adopted children (or children lawfully placed for legal adoption), foster children that live with the Employee and for whom the Employee is the primary source of financial support, and stepchildren. Also included are Your children (or children of Your Spouse or Qualified Domestic Partner) for whom You have legal responsibility resulting from a valid court decree. Mentally, intellectually, or physically impaired children remain covered no matter what age. You must give the Claims Administrator evidence of Your child's incapacity within 31 days of attainment of age 26. The certification form may be obtained from Accolade or Your Employer. This proof of incapacity may be required annually by the Plan. Such children are not eligible under the Plan if they are already 26 or older at the time coverage is effective.

## Detoxification

The process whereby an alcohol or drug intoxicated or alcohol or drug dependent, person is assisted, in a Facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors, or alcohol in combination with drugs, as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

## Developmental Delay

The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an Injury.

## Durable Medical Equipment

Equipment which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease or Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally of use to persons who do not have a disease or Injury; (e) not for exercise or training.

## Effective Date

The date for which the Plan approves an individual application for coverage. For individuals who join the Plan after the first enrollment period, the Effective Date is the date the Claims Administrator approves each future Member according to its normal procedures.

## Elective Surgical Procedure

A surgical procedure that is not considered to be an emergency, and may be delayed by the Member to a later point in time.

## Emergency Medical Condition

("Emergency Services," "Emergency Care," or "Medical Emergency") Emergency Medical Condition means a medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

## Employee

An active full-time or part-time salaried Employee regularly scheduled to work at least 20 hours per week. The Employee is also called the Subscriber.

## Employer
The Plan Sponsor and any of its affiliates and subsidiaries whose employees are authorized by the Plan Sponsor to participate in the Plan.

## ERISA
The Employee Retirement Income Act of 1974, as amended, and the regulations thereunder.

## Experimental/Investigative
Any Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, Injury, illness, or other health condition which the Claims Administrator determines to be unproven.

The Claims Administrator will deem any Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Claims Administrator determined that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Claims Administrator. In determining whether a service is Experimental/Investigative, the Claims Administrator will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the Claims Administrator to determine whether a Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other Federal, state, or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or

- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or Facilities or by other treating Physicians, other medical professionals, or Facilities studying substantially the same Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

The Claims Administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

## Explanation of Benefits (EOB)
See page 85.

## Facility
A Facility, including but not limited to, a Hospital, Freestanding Ambulatory Surgery Center, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health Facility. The Facility must be licensed, accredited, registered or approved by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the Claims Administrator.

## Freestanding Ambulatory Surgery Center
A Facility, with a staff of Physicians, at which surgical procedures are performed on an outpatient basis (no patients stay overnight). The Facility offers continuous service by both Physicians and registered nurses (RNs). It must be licensed and accredited by the appropriate agency and approved by the Claims Administrator. A Physician's office does not qualify as a Freestanding Ambulatory Surgery Center.

## Gender Dysphoria
The distress a person feels due to a mismatch between their gender identity: their personal sense of their own gender and their gender assigned at birth.

## Group Health Plan
An employee welfare benefit plan (as defined in Section 3(1) of ERISA) that provides medical care and is sponsored by the Employer, in effect as of the Effective Date.

## Health Savings Account (HSA)
See page 20.

## Home Health Care
Care, by a licensed program or Provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching, and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

## Home Health Care Agency
A Provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching, and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed and accredited by the appropriate agency.

## Hospice
A Provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed and accredited by the appropriate agency.

## Hospice Care Program
A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual, and social needs of the terminally ill Member and his or her covered family members, by providing palliative and supportive medical, nursing, and other services through at-home or Inpatient care. The Hospice must be licensed and accredited by the appropriate agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

## Hospital
A Facility licensed as a Hospital as required by law that satisfies the Claims Administrator's accreditation requirements and is approved by the Claims Administrator. The term Hospital does not include a Provider, or that part of a Provider, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care, educational care, and subacute care.

## Identification Card
The latest card given to You and viewable on Anthem.com and/or the Sydney Mobile App showing Your identification and group numbers, the type of coverage You have and the date coverage became effective.

## In-For-Out Benefit Treatment
A Covered Service rendered by an Out-of-Network Provider, authorized in advance by the Claims Administrator to be paid at the Network level. This is also referred to as Out-of-Network Referrals.

In some circumstances, such as where there is no Network Provider available for the Covered Service within a radius of 30 miles from Member's home, it will be considered an In-For-Out Benefit.

## Ineligible Charges
Charges for health care services that are not Covered Services because the services are not Medically Necessary or Precertification was not obtained. Such charges are not eligible for payment.

## Ineligible Provider
A Provider which does not meet the minimum requirements to become a contracted Provider with the Claims Administrator. Services rendered to a Member by such a Provider are not eligible for payment.

## Infertile or Infertility
The condition of a presumably healthy Member who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal-ligation or hysterectomy. Infertility services are only available at Blue Distinction Centers. An infertility diagnosis is not required as a condition for fertility treatments. Please refer to "Blue Distinction Surgery Providers" in this section for further information.

## Injury
Bodily harm from a non-occupational accident.

## Inpatient
A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

## Intensive Care Unit
A special unit of a Hospital that: (1) treats patients with serious illnesses or Injuries; (2) can provide special life-saving methods and equipment; (3) admits patients without regard to prognosis; and (4) provides constant observation of patients by a specially trained nursing staff.

## Intensive Outpatient Programs
Structured, multidisciplinary mental health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per day, 3 days per week. Out-of-Network Facility-based Programs must occur at Facilities that are both licensed and accredited.

## Intensivist
A board-certified Physician who provides special care for critically ill patients within the scope of an applicable license, satisfies the Claims Administrator's accreditation requirements, and for Network Providers is approved by the Claims Administrator.

## Inter-Plan Arrangements
See page 85.

## Maternity Care
Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a covered benefit and the newborn infant is an eligible Member under the Plan.

## Maximum Allowed Amount
The maximum amount that the Plan will allow for Covered Services You receive. For more information, please refer to the Claims Payment section.

## Medical Necessity (Medically Necessary)
Procedures, supplies, equipment, or services that we conclude are:

1. Appropriate for the symptoms, diagnosis, or treatment of a medical condition; and
2. Given for the diagnosis or direct care and treatment of the medical condition; and
3. Within the standards of good medical practice within the organized medical community; and
4. Not mainly for the convenience of the Physician or another Provider, and the most appropriate procedure, supply, equipment, or service which can be safely given.

The most appropriate procedure, supply, equipment, or service must meet the following requirements:

1. There must be valid scientific evidence to show that the expected health benefits from the procedure, supply, equipment, or service are clinically significant and will have a greater chance of benefit, without a disproportionately greater risk of harm or complications, than other possible treatments; and
2. Generally approved forms of treatment that are less invasive have been tried and did not work or are otherwise unsuitable; and
3. For Hospital stays, acute care as an Inpatient is needed due to the kind of services the patient needs or the severity of the medical condition, and that safe and adequate care cannot be given as an outpatient or in a less intensive medical setting.

The most appropriate procedure, supply, equipment, or service must also be cost-effective compared to other alternative interventions, including no intervention or the same intervention in an alternative setting. Cost-effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of Your illness, Injury or disease, the service is: (1) not more costly than another service or group of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate. For example, the Plan will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a Specialty Drug provided in the outpatient department of a Hospital if the Drug could be provided in a Physician's office or the home setting.

## Member
Individuals, including the Subscriber and his/her Dependents, who have satisfied the Plan eligibility requirements of the Employer, applied for coverage, and been enrolled for Plan benefits.

## Mental Healthcare
Includes services for mental health and substance abuse. Mental health and substance abuse is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

## Network Provider
A Physician, health professional, Hospital, Pharmacy, or other individual, organization and/or Facility that has entered into a contract, either directly or indirectly, with the Claims Administrator to provide Covered Services to Members through negotiated reimbursement arrangements. A Network Provider for one plan may not be a Network Provider for another. Please refer to "How to Find a Provider in the Network" in the section **How The Plan Works** for more information on how to find a Network Provider for the Plan. The name of the Network for the Plan is listed on Your Identification Card.

## Non-Covered Services
Services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

## Non-Preventive Services
See page 6.

## Out-of-Network Provider
A Provider, including but not limited to, a Hospital, Freestanding Ambulatory Surgery Center, Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services or supplies, that does not have an agreement or contract for this product with the Claims Administrator to provide services to its Members at the time services are rendered.

Benefit payments and other provisions of the Plan are limited when a Member uses the services of Out-of-Network Providers.

## Out-of-Network Referrals
A Covered Service rendered by an Out-of-Network Provider, authorized in advance by the Claims Administrator to be paid at the Network level. This is also referred to as In-For-Out Benefit Treatment.

## Out-of-Pocket Maximum
The maximum amount of a Member's Coinsurance payments during a given Calendar Year. When the Out-of-Pocket Maximum is reached, the level of benefits is increased to 100% of the Maximum Allowed Amount for Covered Services.

## Partial Hospitalization
Structured, multidisciplinary mental health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than 6 hours per day, 5 days per week. Out-of-Network Facility-based Programs must occur at Facilities that are both licensed and accredited.

## Physical Therapy
The care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care.

## Physician
Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor, any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery, Optometrists, and Clinical Psychologists (PhD) are also Providers when acting within the scope of their licenses, and when rendering services covered under the Plan.

## Plan
The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer's medical benefits, as described herein. This Benefit Booklet in conjunction with the Administrative Services Agreement, the application, if any, any amendment or rider, Your Identification Card, Your application for enrollment and the relevant portions of The Bank of New York Mellon Health and Welfare Plan constitutes the entire Plan.

## Plan Administrator
The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details as provided in The Bank of New York Mellon Health and Welfare Plan. **The Plan Administrator is not the Claims Administrator.**

## Plan Sponsor
The Bank of New York Mellon Corporation, which is the legal entity that has adopted the Plan and has authority regarding its operation, amendment, and termination. **The Plan Sponsor is not the Claims Administrator.**

## Post-service Review
See page 50.

## Precertification
See page 50.

## Preferred Provider Organization (PPO)
See page 6.

## Prescription Drug/(Drug)
A medicine that is approved by the Food & Drug Administration (FDA) to treat illness or Injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a Prescription." This includes the following:

- Compounded (combination) medications, when all of the ingredients are FDA-approved, require a Prescription to dispense, and are not essentially the same as an FDA-approved product from a Drug manufacturer.
- Insulin.

## Prescription Order or Prescription
A written request by a Provider, as permitted by law, for a Drug or medication and each authorized refill for same.

## Pre-service Review
See page 50.

## Preventive Services
See page 70

## Primary Care Physician
A Provider who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics, or any other Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

## Prior Authorization/Precertification/Preauthorization
The process applied to certain Drugs and/or therapeutic categories to define and/or limit the conditions under which these Drugs or therapeutic categories will be covered. The Drugs and therapeutic categories and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

## Provider
A professional or Facility licensed when required by law that provides healthcare services within the scope of an applicable license, satisfies the Claims Administrator's accreditation requirements, and for Network Providers, is approved by the Claims Administrator. This includes any Provider rendering services which are required by applicable law to be covered when rendered by such Provider. Providers that deliver Covered Services are described throughout this Benefit Booklet. If You have a question about a Provider not described in this Benefit Booklet, please call the number on the back of Your Identification Card.

## Qualified Domestic Partner
A Qualified Domestic Partner is a person (whether of the same or opposite sex) in a "spouse-like" relationship with an eligible Employee, and who, together with the eligible Employee:

- are each other's sole qualified domestic partner and intend to remain so indefinitely;
- are at least eighteen (18) years of age and competent to enter into a legal contract;
- are not related in any way that would prevent them from being legally married;
- are not legally married to anyone else, and all prior marriages have ended by such means as death, divorce, dissolution, or annulment;
- are not qualified domestic partners with anyone else, and any prior domestic partnerships have ended by such means as death or dissolution;
- share joint responsibility for each other's welfare and financial obligations;
- share a household that is the primary residence of both (although they may live apart for reasons of education, healthcare, work or military service); and

are registered domestic partners with any state or local government domestic partnership registry, if residing in a state or locality that provides domestic partner registration.

## Quick Care Options
See page 46.

## QMCSO, or MCSO – Qualified Medical Child Support Order or Medical Child Support Order
A QMCSO creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the Plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the Plan, the period for which coverage must be provided and each plan to which the order applies.

An MCSO is any court judgment, decree, or order (including a court's approval of a domestic relations settlement agreement) that:

- Provides for child support payment related to health benefits with respect to the child of a Member or requires health benefit coverage of such child in the Plan, and is ordered under state domestic relations law; or
- Enforces a state law relating to medical child support payment with respect to the Employer's Group Health Plan.

## Residential Treatment Center/Facility
An Inpatient Facility that treats mental health and substance abuse conditions. The Facility must be licensed as a Residential Treatment Center in the state in which it is located and be accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial care
- Educational care

## Retail Health Clinic
A Facility that provides limited basic medical care services to Members on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

## Semiprivate Room
A Hospital room which contains two or more beds.

## Skilled Convalescent Care
Care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient's home or in a nursing home not certified as a Skilled Nursing Facility.

## Skilled Nursing Facility
A Facility licensed as a Skilled Nursing Facility in the state in which it is located that satisfies the Claims Administrator's accreditation requirements and, for Network Facilities, is approved by the Claims Administrator.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care, or domiciliary care, or a place for rest, educational, or similar services.

## Specialist (Specialty Care Physician\Provider or SCP)
A Specialist is a doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

## Specialty Drugs
Typically high-cost Drugs that are injected or infused in the treatment of acute or chronic diseases. Specialty Drugs often require special handling such as temperature-controlled packaging and expedited delivery. Most Specialty Drugs require Preauthorization to be considered Medically Necessary.

## Spouse
A person to whom You are legally-married, who is treated as Your spouse or surviving spouse pursuant to the Code and ERISA, and for whom the marriage has not ended by such means as divorce, dissolution, annulment or death.

## Surprise Billing Claim
Please refer to the **Consolidated Appropriations Act of 2021 Notice** in the **Health Benefits Coverage Under Federal Law** section for details.

## Sydney Mobile App
See page 46.

## Telehealth
Consultations with Your Provider (PCP/Specialist) using visual and audio (Computer, Smart Phone, Tablet).

## Telephonic
Consultations with Your Provider (PCP/Specialist) using audio only (telephone).

## Therapeutic Equivalent
Therapeutic/Clinically Equivalent Drugs are Drugs that can be expected to produce similar therapeutic outcomes for a disease or condition.

## Transplant Providers

**Network Transplant Provider** – Transplant services are only available at Blue Distinction Centers. Please refer to "Blue Distinction Surgery Providers" in this section for further information. Such Provider has entered into a Transplant Provider agreement to render Covered Transplant Procedures and certain administrative functions to You for the transplant network. A Provider may be a Network Transplant Provider with respect to:

- certain Covered Transplant Procedures; or
- all Covered Transplant Procedures.
- **Out-of-Network Transplant Provider** – Any Provider that has NOT been designated as a "Center of Medical Excellence" for Transplants by the Claims Administrator or has not been selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association.

## Urgent Care
Services received for a sudden, serious, or unexpected illness, Injury, or condition. Urgent Care is not considered an emergency. Care is needed right away to relieve pain, find out what is wrong, or treat a health problem that is not life-threatening.

## Utilization Review
Evaluation of the necessity, quality, effectiveness, or efficiency of medical or mental health services, procedures, and/or Facilities.

## Virtual Primary Care
On-demand and scheduled secure medical text-chat and video visits for Urgent Care and primary care spanning Urgent Care, prevention and wellness, and condition management for adults ages 18-64.

## Virtual Video Visits (LiveHealth Online)

Virtual Video Visits are also known as LiveHealth Online. These visits are a method of consulting with Medical and Behavioral Health Providers using visual and/or audio devices (Computer, Smart Phone, Tablet).

## You and Your

Refer to the Subscriber, Member and each Covered Dependent.

# HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW

## Choice of Primary Care Physician

The Plan generally allows the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in the Claims Administrator's Network and who is available to accept You or Your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of Your Identification Card or please refer to the Claims Administrator's website, www.anthem.com. For children, You may designate a pediatrician as the PCP.

## Access to Obstetrical and Gynecological (ObGyn) Care

You do not need Prior Authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services or following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of Your Identification Card or please refer to the Claims Administrator's website, www.anthem.com**.**

## Consolidated Appropriations Act of 2021 (CAA)

The Consolidated Appropriations Act of 2021 (CAA) is a Federal law that includes the No Surprises Act as well as the Provider transparency requirements that are described below.

## Surprise Billing Claims

Surprise Billing Claims are claims for the following Services, subject to the No Surprises Act requirements as further described below:

- Emergency Services provided by Out-of-Network Providers;
- Covered Services provided by an Out-of-Network Provider at a Network Facility; and
- Out-of-Network Air Ambulance Services.

**No Surprises Act Requirements**

*Emergency Services*

As required by the CAA, Emergency Services are covered under Your Plan:

- Without the need for Precertification;
- Whether the Provider is Network or Out-of-Network;

If the Emergency Services You receive are provided by an Out-of-Network Provider, Covered Services will be processed at the Network benefit level.

Note that if You receive Emergency Services from an Out-of-Network Provider, Your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by a Network Provider. However, Out-of-Network cost-shares (i.e., Copayments, Deductibles and/or Coinsurance) will apply to Your claim if the treating Out-of-Network Provider determines You are stable, meaning You have been provided necessary Emergency Care such that Your condition will not materially worsen and the Out-of-Network Provider determines: (i) that You are able to travel to a Network Facility by non-emergency transport; (ii) the Out-of-Network Provider complies with the notice and consent requirement; and (iii) You are in condition to receive the information and provide informed consent. If You continue to receive services from the Out-of-Network Provider after You are stabilized, You will be responsible for the Out-of-Network cost-shares, and the Out-of-Network Provider will also be able to charge You any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charges. This notice and consent exception does not apply if the Covered Services furnished by an Out-of-Network Provider result from unforeseen and urgent medical needs arising at the time of service.

*Out-of-Network Services Provided at a Network Facility*

When You receive Covered Services from an Out-of-Network Provider at a Network Facility, Your claims will be paid at the Out-of-Network benefit level if the Out-of-Network Provider gives You proper notice of its charges, and You give written consent to such charges. This means You will be responsible for Out-of-Network cost-shares for those services and the Out-of-Network Provider can also charge You any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charges. This requirement does not apply to Ancillary Services, meaning such Services will be processed at the Network benefit level. Ancillary Services are one of the following services: (A) Emergency Services; (B) anesthesiology; (C) laboratory and pathology services; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (H) Hospitalists; (I) Intensivists; and (J) any services set out by the U.S. Department of Health & Human Services. In addition, Anthem will not apply this notice and consent process to You and the Covered Services will be processed at the Network benefit level if Anthem does not have a Network Provider in Your area who can perform the services You require.

*Post-stabilization*

Post-stabilization consists of a four-part test:

1. The attending Physician determines that the Member is able to travel using nonmedical transportation to a Network Provider or Facility within a reasonable distance, taking into consideration the Member's medical condition;
2. The Network Provider/Facility satisfies notice and consent criteria;
3. The Member or their authorized representative must be in the condition to provide informed and voluntary consent; and
4. The Network Provider/Facility must satisfy any additional state law requirements.

Out-of-Network Providers satisfy the notice and consent requirement as follows:

- By obtaining Your written consent not later than 72 hours prior to the delivery of services; or
- If the notice and consent is given on the date of the service, if You make an appointment within 72 hours of the services being delivered.

*How Cost-Shares Are Calculated*

The Maximum Allowed Amount will be used to determine payment for Emergency Care from an Out-of-Network Provider. However, Member cost-share will be based on the median Plan Network contract rate paid to Network Providers for the geographic area where the service is provided.

*Appeals*

If You receive Emergency Services from an Out-of-Network Provider or Covered Services from an Out-of-Network Provider at a Network Facility and believe those services are covered by the No Surprises Act, You have the right to appeal a denied claim. If Your appeal of a Surprise Billing Claim is denied, then You have a right to appeal the adverse decision to an Independent Review Organization as set out in the **Your Right To Appeal** section of this Benefit Book.

## Provider Directories

Anthem is required to confirm the list of Network Providers in its Provider directory every 90 days. If You can show that You received inaccurate information from Anthem that a Provider was listed as in Network on a particular claim, then You will only be liable for Network cost-shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your Network cost-shares will be calculated based upon the Maximum Allowed Amount.

## Transparency Requirements

Anthem provides at its website, anthem.com, protections with respect to Surprise Billing Claims by Providers, including information on how to contact state and Federal agencies if You believe a Provider has violated the No Surprises Act. You can find this information directly at https://www.anthem.com/no-surprise-billing/

You may also obtain the following information on Anthem's website or by calling Member Services at the phone number on the back of Your Identification Card:

- Cost sharing information for 500 defined services, as required by the Centers for Medicare & Medicaid Services (CMS); and
- A listing / directory of all Network Providers.

In addition, Anthem will provide access through its website to the following information:

- Network negotiated rates; and
- Historical Out-of-Network rates.

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Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross and Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Health Services Insurance Corporation (Compcare) or Wisconsin Collaborative Insurance Company (WCIC). Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

# IT’S IMPORTANT WE TREAT YOU FAIRLY

That’s why we follow Federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or impairment. For people with impairments, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Accolade Member Services number on Your Identification Card for help (TTY/TDD: 711). If You think we failed to offer these services or discriminated based on race, color, national origin, age, impairment, or sex, You can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or You can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

# 2020-2023 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

This comparison of the essential health insurance benefits regulated by the State of Illinois and those covered by the applicable BNY Mellon sponsored benefits plan is being provided to employees in Illinois in accordance with the terms of the Illinois Consumer Coverage Disclosure Act. Please note that medical benefits and Pharmacy benefits are administered under separate BNY Mellon sponsored plans.

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|---|---|
| **Employer Name:** | Subsidiary of The Bank of New York Mellon Corporation |
| **Employer State of Situs:** | **IN**<br><br>(Comparison chart provided to employees in Illinois in accordance with the terms of the Illinois Consumer Coverage Disclosure Act.) |
| **Name of Issuer:** | **Anthem** |
| **Plan Marketing Name:** | |
| **Calendar Year:** | **2023** |

**Ten (10) Essential Health Benefit (EHB) Categories:**

**- Ambulatory patient services (outpatient care you get without being admitted to a hospital)**
**- Emergency services**
**- Hospitalization (like surgery and overnight stays)**
**- Laboratory services**
**- Mental health and substance use disorder (MH/SUD) services, including mental health treatment (this includes counseling and psychotherapy)**
**- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)**
**- Pregnancy, maternity, and newborn care (both before and after birth)**
**- Prescription drugs**
**- Preventive and wellness services and chronic disease management**
**- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)**

**2020-2023 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)**

| Item | EHB Benefit | EHB Category | Benchmark Page # Reference | Employer Plan Covered Benefit? |
|---|---|---|---|---|
| 1 | Accidental Injury -- Dental | Ambulatory | Pgs. 10 & 17 | Yes |
| 2 | Allergy Injections and Testing | Ambulatory | Pg. 11 | Yes |

| | | | | |
|---|---|---|---|---|
| **3** | **Bone anchored hearing aids** | **Ambulatory** | **Pgs. 17 & 35** | **Yes. $5,000 Every 24 Months. See hearing aid benefit in Schedule of Benefits.** |
| **4** | **Durable Medical Equipment** | **Ambulatory** | **Pg. 13** | **Yes** |
| **5** | **Hospice** | **Ambulatory** | **Pg. 28** | **Yes** |
| **6** | **Infertility (Fertility) Treatment** | **Ambulatory** | **Pgs. 23 - 24** | **Yes** |
| **7** | **Outpatient Facility Fee (e.g., Ambulatory Surgery Center)** | **Ambulatory** | **Pg. 21** | **Yes** |
| **8** | **Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)** | **Ambulatory** | **Pgs. 15 - 16** | **Yes** |
| **9** | **Private-Duty Nursing** | **Ambulatory** | **Pgs. 17 & 34** | **Yes** |
| **10** | **Prosthetics/Orthotics** | **Ambulatory** | **Pg. 13** | **Yes** |
| **11** | **Sterilization (vasectomy men)** | **Ambulatory** | **Pg. 10** | **Yes** |
| **12** | **Temporomandibular Joint Disorder (TMJ)** | **Ambulatory** | **Pgs. 13 & 24** | **No** |
| | | | | |
| **13** | **Emergency Room Services (Includes MH/SUD Emergency)** | **Emergency services** | **Pg. 7** | **Yes** |
| **14** | **Emergency Transportation/ Ambulance** | **Emergency services** | **Pgs. 4 & 17** | **Yes** |
| | | | | |
| **15** | **Bariatric Surgery (Obesity)** | **Hospitalization** | **Pg. 21** | **Yes** |
| **16** | **Breast Reconstruction After Mastectomy** | **Hospitalization** | **Pgs. 24 - 25** | **Yes** |
| **17** | **Reconstructive Surgery** | **Hospitalization** | **Pgs. 25 - 26, & 35** | **Yes** |
| **18** | **Inpatient Hospital Services (e.g., Hospital Stay)** | **Hospitalization** | **Pg. 15** | **Yes** |
| **19** | **Skilled Nursing Facility** | **Hospitalization** | **Pg. 21** | **Yes** |
| **20** | **Transplants - Human Organ Transplants (Including transportation & lodging)** | **Hospitalization** | **Pgs. 18 & 31** | **Yes** |
| | | | | |
| **21** | **Diagnostic Services** | **Laboratory services** | **Pgs. 6 & 12** | **Yes** |
| | | | | |
| **22** | **Intranasal opioid reversal agent associated with opioid prescriptions** | **MH/SUD** | **Pg. 32** | **Medical: Outpatient prescription drugs prescribed by a physician and purchased or obtained from a retail pharmacy or retail pharmacist or a mail service pharmacy are excluded. These may be covered by a separate drug card program but not under this medical plan. Pharmacy: Yes** |

| | | | | |
|---|---|---|---|---|
| **23** | **Mental (Behavioral) Health Treatment (Including Inpatient Treatment)** | **MH/SUD** | **Pgs. 8 -9, 21** | **Yes** |
| **24** | **Opioid Medically Assisted Treatment (MAT)** | **MH/SUD** | **Pg. 21** | **Medical: Outpatient prescription drugs prescribed by a physician and purchased or obtained from a retail pharmacy or retail pharmacist or a mail service pharmacy are excluded. These may be covered by a separate drug card program but not under this medical plan. Pharmacy: Yes** |
| **25** | **Substance Use Disorders (Including Inpatient Treatment)** | **MH/SUD** | **Pgs. 9 & 21** | **Yes** |
| **26** | **Tele-Psychiatry** | **MH/SUD** | **Pg. 11** | **Yes** |
| **27** | **Topical Anti-Inflammatory acute and chronic pain medication** | **MH/SUD** | **Pg. 32** | **Medical: Outpatient prescription drugs prescribed by a physician and purchased or obtained from a retail pharmacy or retail pharmacist or a mail service pharmacy are excluded. These may be covered by a separate drug card program but not under this medical plan. Pharmacy: Yes** |
| | | | | |
| **28** | **Pediatric Dental Care** | **Pediatric Oral and Vision Care** | **See AllKids Pediatric Dental Document** | **Dental Covered for treatment of an injury to sound and natural teeth. Only if treatment is completed within 12 months of the accident. Unless delay is medically necessary. Otherwise dental services are not covered under the medical plan.** |
| **29** | **Pediatric Vision Coverage** | **Pediatric Oral and Vision Care** | **Pgs. 26 - 27** | **Routine visions screenings are covered.** |
| | | | | |
| **30** | **Maternity Service** | **Pregnancy, Maternity, and Newborn Care** | **Pgs. 8 & 22** | **Yes** |
| | | | | |

| | | | | |
|---|---|---|---|---|
| **31** | **Outpatient Prescription Drugs** | **Prescription drugs** | **Pgs. 29 - 34** | **Medical: Outpatient prescription drugs prescribed by a physician and purchased or obtained from a retail pharmacy or retail pharmacist or a mail service pharmacy are excluded. These may be covered by a separate drug card program but not under this medical plan. Pharmacy: Yes** |
| | | | | |
| **32** | **Colorectal Cancer Examination and Screening** | **Preventive and Wellness Services** | **Pgs. 12 & 16** | **Yes** |
| **33** | **Contraceptive/Birth Control Services** | **Preventive and Wellness Services** | **Pgs. 13 & 16** | **Yes** |
| **34** | **Diabetes Self-Management Training and Education** | **Preventive and Wellness Services** | **Pgs. 11 & 35** | **Yes** |
| **35** | **Diabetic Supplies for Treatment of Diabetes** | **Preventive and Wellness Services** | **Pgs. 31 - 32** | **Yes** |
| **36** | **Mammography - Screening** | **Preventive and Wellness Services** | **Pgs. 12, 15, & 24** | **Yes** |
| **37** | **Osteoporosis - Bone Mass Measurement** | **Preventive and Wellness Services** | **Pgs. 12 & 16** | **Yes** |
| **38** | **Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test** | **Preventive and Wellness Services** | **Pg. 16** | **Yes** |
| **39** | **Preventive Care Services** | **Preventive and Wellness Services** | **Pg. 18** | **Yes** |
| **40** | **Sterilization (women)** | **Preventive and Wellness Services** | **Pgs. 10 & 19** | **Yes** |
| | | | | |
| **41** | **Chiropractic & Osteopathic Manipulation** | **Rehabilitative and Habilitative Services and Devices** | **Pgs. 12 - 13** | **Yes** |
| **42** | **Habilitative and Rehabilitative Services** | **Rehabilitative and Habilitative Services and Devices** | **Pgs. 8, 9, 11, 12, 22, & 35** | **Physical, Occupational and Speech Therapy are limited to 60 visits per calendar year. Additional visits can be approved based on Medical Necessity** |
| ***Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.*** | | | | |

# GET HELP IN YOUR LANGUAGE

Curious to know what all this says? We would be too. Here's the English version:

You have the right to get this information and help in Your language for free. Call the Accolade Member Services number on Your Identification Card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for Members with visual impairments. If You need a copy of this document in an alternate format, please call the Accolade Member Services telephone number on the back of Your Identification Card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian
Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Amharic
ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ።(TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD: 711).

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Bassa
Ǹ bédé dyí-bɛ̀dɛ̀ìn-dɛ̀ɔ̀ bɛ́ m̀ ké bɔ̌ nìà kɛ kè gbo-kpá- kpá dyé dé m̀ bídí-wùdùǔn bó pídyi. Đá méɓà jè gbo-gmɔ̀ Kpòè nɔ̀ɓà nìà nì Dyí-dyoìn-bɛ̃̂ɔ̃ kɔ̃ɛ bé m̀ ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

Bengali
আপনার বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন।(TTY/TDD: 711)

Burmese
ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရပိုင်ခွင့် သင့်တွင်ရှိပါသည်။
အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။
(TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。
(TTY/TDD: 711)

Dinka
Yin nɔŋ yic ba ye lëk në yök ku bë yi kuɔny në thöŋ yin jäm ke cin wëu töu kë piiny. Cɔl rän töŋ dë kɔc kë luɔi në nämba dën tö në I.D kat du yic. (TTY/TDD: 711)

Dutch
U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstennummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d’accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d’identification. (TTY/TDD: 711)

German
Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Greek
Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (Identification card) για βοήθεια. (TTY/TDD: 711)

Gujarati
તમે તમારી ભાષામાં મફતમાં આ માહિતી અને મદદ મેળવવાનો અધિકાર ધરાવો છો. મદદ માટે તમારા આઈડી કાર્ડ પરના મેમ્બર સર્વિસ નંબર પર કોલ કરો. (TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Hindi
आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Hmong
Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Igbo
Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

Ilokano
Addanka ti karbengan a maala iti daytoy nga impormasyon ken tulong para ti lengguahem nga awanan ti bayadna. Awagan ti numero ti Serbisyo para ti Kameng a masarakan ayan ti ID kard mo para ti tulong. (TTY/TDD: 711)

Indonesian
Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer
អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។ (TTY/TDD: 711)

Kirundi
Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Lao
ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກທີ່ໃຫ້ໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. (TTY/TDD: 711)

Navajo
Bee ná ahoot'i' táá ni nizaad k'ehjínikáá á a'doowol t'áá jíík'e. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitinígíí béésh bee hane'í bikáá' áaji' hodíílnih. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitinígíí béésh bee hane'í bikáá' áají' hodíílnih. (TTY/TDD: 711)

Nepali
तपाईंले यो जानकारी तथा सहयोग आफ्नो भाषामा निःशुल्क प्राप्त गर्ने तपाईंको अधिकार हो। सहायताको लागि तपाईंको ID कार्डमा दिइएको सदस्य सेवा नम्बरमा कल गर्नुहोस्। (TTY/TDD: 711)

Oromo
Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Pennsylvania Dutch
Du hoscht die Recht selle Information un Helfe in dei Schprooch mitaus Koscht griege. Ruf die Member Services Nummer uff dei ID Kaarte fer Helfe aa. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe
Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Romanian
Aveți dreptul să obțineți aceste informații și asistență în limba dvs. în mod gratuit. Pentru asistență, apelați numărul departamentului de servicii destinate membrilor de pe cardul dvs. de identificare. (TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Samoan
E iai lou ‘aia faaletulafono e maua nei faamatalaga ma se fesoasoani i lou lava gagana e aunoa ma se totogi. Vili le numera mo Sauniuniga mo lou Vaega o loo maua i lou pepa faailoa ID mo se fesoasoani. (TTY/TDD: 711)

Serbian
Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong Identification card para sa tulong. (TTY/TDD: 711)

Thai
**ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี**
**โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ** (TTY/TDD: 711)

Ukrainian
Ви маєте право безкоштовно отримати інформацію та допомогу своєю рідною мовою. По допомогу звертайтеся за номером служби підтримки учасників програми страхування, указаним на вашій ідентифікаційній картці. (TTY/TDD: 711)

Urdu
آپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔(TTY/TDD:711)۔

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yiddish
רופט די מעמבער איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם.
באדינונגען נומער אויף אייער קארטל פאר הילף (TTY/TDD:711)

Yoruba
O ní ẹ̀tọ́ láti gba ìwífún yìí kí o sì ṣèrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Pe Nọ́mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́. (TTY/TDD: 711)