Benefits Summary

Fidelity Health Plan

Effective: January 1, 2021

Group Number: 76-413512

BENEFITS ADMINISTERED BY

UMR℠

A UnitedHealthcare Company

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SECTION 1 - WELCOME

Quick Reference Box

- Accolade member services, claim inquiries: 1-844-287-3861
- Medical claim submittal address: See Section 7 ("Claims Procedures")
- Behavioral health claim submittal address: See Section 7 ("Claims Procedures")
- Online assistance: **member.accolade.com**
- Pharmacy claims and prescription drug program: CVS Caremark 1-800-446-3709

This Benefits Summary for the Fidelity Health Plan (the "Plan") offered by FMR LLC ("Fidelity" or the "Company") describes the health Benefits available under the Plan. It includes summaries of:

- Services that are covered, called Covered Health Services.
- Services that are not covered, called Exclusions and Limitations.
- How Benefits are paid.

This Benefits Summary is designed to supplement your information needs and is incorporated by reference into the Summary Plan Description (SPD) prepared by Fidelity and available on FMRbenefits.com or by calling the Fidelity Benefits Center at 800-835-5099. This Benefits Summary supersedes any prior printed or electronic version of this Benefits Summary.

Note: The Prescription Drug Program, which is administered by CVS Caremark, is a component of the Plan and is described in the Prescription Drug Benefit Booklet. If you are enrolled in the Plan, you are automatically enrolled in the Prescription Drug Program as well. For information about pharmacy claims and the Prescription Drug Program, contact CVS Caremark Customer Care toll free at 1-800-446-3709, visit **caremark.com** or contact Accolade.

IMPORTANT

The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 10, *Glossary*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, Substance-Related and Addictive Disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Fidelity intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan in whole or in part at any time, for any reason, and without prior notice.

UMR is a healthcare Claims Administrator that Fidelity has contracted with to administer claims for this self-funded plan. Although UMR will assist you in many ways, it does not guarantee any Benefits. Fidelity is solely responsible for paying Benefits described in this Benefits Summary.

Please read this Benefits Summary thoroughly to learn how the Plan works. If you have questions contact the Fidelity Benefits Center at 800-835-5099 (TDD 888-343-0860) or call the number on the back of your ID card.

How To Use This Benefits Summary

- Read the entire Benefits Summary, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this Benefits Summary are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your Benefits Summary and any updated versions at FMR**benefits.com** or request printed copies by calling the Fidelity Benefits Center at 800-835-5099 (TDD 888-343-0860).
- Capitalized words in the Benefits Summary have special meanings and are defined in Section 10, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 10, *Glossary*.
- FMR LLC is also referred to as Company or Fidelity.

SECTION 2 - HOW THE PLAN WORKS

What this section includes:

- Accessing Benefits.
- Eligible Expenses.
- Annual Deductible.
- Coinsurance.
- Out-of-Pocket Maximum.

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Network Benefits or Non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Physician in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or *PCP*.

Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. In general health care terminology, Non-Network Benefits may also be referred to as out-of-network Benefits.

Depending on the geographic area and the service you receive, you may have access through UMR's Cost Reduction Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Cost Reduction Savings Program in Section 10, *Glossary*, of the Benefits Summary for details about how the Cost Reduction Savings Program applies.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

Employees who live in Massachusetts, Maine and New Hampshire (and their covered Dependents regardless of where those Dependents live) will receive in Network coverage through the Harvard Pilgrim Health Care Network when seeking Covered Health Services in Massachusetts, Maine and New Hampshire or through the UnitedHealthcare Choice Plus Network when seeking Covered Health Services outside Massachusetts, Maine and New Hampshire.

Employees who live outside Massachusetts, Maine and New Hampshire (and their covered Dependents regardless of where those Dependents live) will receive in Network coverage through the UnitedHealthcare Choice Plus Network.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits when Covered Health Services are received from a non-Network provider. In this situation, your Network Physician will notify UMR, and if UMR confirms that care is not available from a Network provider, UMR will work with you and your Network Physician to coordinate care through a non-Network provider.

If no Network provider is available or willing to provide necessary services within a 30 mile radius of the Covered Person's residence, the Covered Person may be eligible to receive Network Benefits from a non-Network provider. In this situation your Network Physician will notify the Claims Administrator, who will work with you and your Network Physician to coordinate care through a non-Network provider. Covered Persons should contact Accolade to confirm Network providers.

Looking for a Network Provider?
In addition to other helpful information, **UMR.com,** UMR's consumer website, contains a directory of health care professionals and facilities in Network. While Network status may change from time to time, **UMR.com** has the most current source of Network information. Use **UMR.com** to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call Accolade at 1-844-287-3861 or log onto **member.accolade.com**.

Network providers are independent practitioners and are not employees of Fidelity or UMR.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling Accolade. A directory of providers is available online at **member.accolade.com** or by calling the number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The Network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact Accolade at the number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with Networks to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some products. Refer to the directory online of providers, available at member.accolade.com or contact Accolade for assistance.

Designated Providers

If you have a medical condition that UMR believes needs special services, UMR may direct you to a Designated Provider chosen by UMR. If you require certain complex Covered Health Services for which expertise is limited, UMR may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Provider, UMR may reimburse certain travel expenses at UMR's discretion.

Network Benefits may only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Provider or other provider chosen by UMR.

You or your Network Physician must notify UMR of special service needs that might warrant referral to a Designated Provider

Eligible Expenses

Fidelity has delegated to UMR the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UMR determines that UMR will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UMR will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UMR's reimbursement policy guidelines, as described in the Benefits Summary.

For Network Benefits, Eligible Expenses for Covered Health Services are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are the Network's contracted fee(s) with that provider.

For Non-Network Benefits, Eligible Expenses for Covered Health Services received from providers, including physicians or health care facilities, who are non-Network are determined based on one of the following:

- Negotiated rates agreed to by the non-Network provider and either UMR or one of UMR's vendors, affiliates or subcontractors, at UMR's discretion;
- The amount that is usually charged by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment based on the 80th percentile; or
- Using currently publicly available data reflecting the costs for health care providers providing the same or similar services, adjusted for geographical differences plus a margin factor.

When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UMR, Eligible Expenses are an amount negotiated by the UMR vendors or an amount permitted by law. Please contact the Accolade if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any Deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

For services received from a non-Network provider, claims for Covered Health Services will normally be processed in accordance with the Non-Network benefit levels that are listed on the Schedule of Benefits. These non-Network providers charge their normal rates for services, so Covered Persons may need to pay more. Covered Persons are responsible for paying the balance of these claims after the Plan pays its portion, if any.

> ***IMPORTANT NOTICE***: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Don't Forget Your ID Card
Remember to show your ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Eligible Expenses charged by both Network and non-Network providers apply towards both the Network individual and family Deductibles and the non-Network individual and family Deductibles.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.
The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided under the Prescription Drug Program.

Eligible Expenses charged by both Network and non-Network providers apply toward both the Network individual and family Out-of-Pocket Maximums and the non-Network individual and family Out-of-Pocket Maximums.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes	Yes
Prescription copays for Covered Health Services under the Prescription Drug Program	Yes	Yes
Coinsurance Payments, including the Coinsurance for Covered Health Services under the Prescription Drug Program	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No	No
Charges that exceed Eligible Expenses	No	No

SECTION 3 - CASE MANAGEMENT AND PRIOR AUTHORIZATION

What this section includes:

- An overview of Case Management and Prior Authorization requirements.
- Covered Health Services which require prior authorization.

Case Management

Case Management Services are provided through Accolade.

Accolade Health Assistants and nurses provide intensive management and support for individuals, and their families, with multiple chronic diseases, critical or traumatic events, and highly complex and high-acuity diagnoses.

Accolade Health Assistants and nurses can conduct assessments and gather information about the individual's situation to create a care plan that addresses key health problems and other needs. They can work directly with the appropriate resources as needed to organize care for the individual. This holistic care plan is developed with specific goals, education and actions necessary to support individuals to reach their optimal health and wellbeing.

Accolade's Health Assistants and nurses are trained in helping individuals with complex needs, and are supported by pharmacists, licensed clinical social workers, behavioral health experts, and medical directors.

Connect with your Accolade Health Assistant or nurse via phone, online or mobile. Call 844-287-3861 Monday through Friday, 8 AM to 10 PM EST (nurses also available after hours), visits member.accolade.com or download the Accolade mobile app.

Accolade does not practice medicine or provide patient care. It is an independent resource to support and assist you as you use the healthcare system and receive medical care from your own doctors, nurses and healthcare professionals. If you have a medical Emergency, please contact 911 immediately.

Prior Authorization

Certain Covered Health Services require prior authorization. In general, your Network Primary Physician and other Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. For detailed information on the Covered Health Services that require prior authorization, please refer to Section 5, *Additional Coverage Details*.

It is recommended that you confirm with Accolade that all Covered Health Services have been prior authorized as required. All services that require prior authorization are listed in Section 5, *Additional Coverage Details*. Before receiving these services from a Network provider, you may want to contact Accolade to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact Accolade by calling the number on the back of your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers.

To obtain prior authorization, call the number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

If you have questions about your coverage, need help finding a new provider, have claims or billing questions or need to understand your care options, ask Accolade by calling the member services number on the back of your ID card, visiting **member.accolade.com**, or texting M2F8 to 67793 to download the Accolade mobile app.* Your Health Assistant is your first line of support to help with any health or health benefit question, big or small.

*Message and data charges may apply. Visit **accolade.com** for privacy policy

Network providers are generally responsible for obtaining prior authorization from the Claims Administrator before they provide certain services to you. However, there are some Network Benefits for which you are responsible for obtaining prior authorization from the Claims Administrator.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator before you receive these services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization.

Services for which you are required to obtain prior authorization are identified in Section 5, *Additional Coverage Details*, within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in Section 8, *Coordination of Benefits (COB)*. You are not required to obtain authorization before receiving Covered Health Services.

SECTION 4 - PLAN HIGHLIGHTS

What this section includes:
- Payment Terms and Features.
- Schedule of Benefits.

Payment Terms and Features

The table below provides an overview of the Plan's Annual Deductible and Out-of-Pocket Maximum when you receive certain Covered Health Services.

Plan Features	Network Amounts	Non-Network Amounts
Annual Deductible ■ Individual. ■ Family (cumulative Annual Deductible). The Plan does not require that you or a covered Dependent meet the individual Deductible in order to satisfy the family Deductible. If more than one person in a family is covered under the Plan, the individual coverage Deductible stated in this table above does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits until the family Deductible is satisfied.	$1,500 $3,000	$3,000 $6,000
Annual Out-of-Pocket Maximum ■ Individual. ■ Family (cumulative Out-of-Pocket Maximum). The Plan does not require that you or a covered Dependent meet the individual Out-of-Pocket Maximum in order to satisfy the family Out-of-Pocket Maximum. If more than one person in a family is covered under the Plan, the individual coverage Out-of-Pocket Maximum stated in this table above does not apply. Instead, for family coverage the family Out-of-Pocket Maximum applies.	$2,000 $4,000	$4,000 $8,000

Plan Features	Network Amounts	Non-Network Amounts
The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services, including Covered Health Services provided under the Prescription Drug Program.		
Lifetime Maximum Benefit There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan. Generally the following are considered to be essential Benefits under the *Patient Protection and Affordable Care Act:* Ambulatory patient services; Emergency services, hospitalization; maternity and newborn care; mental health and Substance-Related and Addictive Disorders services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care).	Unlimited	

Schedule of Benefits

This table provides an overview of the Fidelity Health Plan coverage levels. For detailed descriptions of your Benefits, refer to Section 5, *Additional Coverage Details*.

Covered Health Services[1]	**Benefit** ***(The Amount Payable by the Plan based on Eligible Expenses)***	
	Network	**Non-Network**
Acupuncture Services See Section 5, *Additional Coverage Details*, for limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Ambulance Services - Emergency Only	*Ground and/or Air Ambulance* 90% after you meet the Annual Deductible	*Ground and/or Air Ambulance* Same as Network
Ambulance Services - Non-Emergency Ground or air ambulance, as the Claims Administrator determines appropriate.	*Ground and/or Air Ambulance* 90% after you meet the Annual Deductible	*Ground and/or Air Ambulance* Same as Network
Cancer Resource Services See *Cancer Resource Services (CRS)* in Section 5, *Additional Coverage Details*. *This section refers to the Cancer Resource Services (CRS) Program only.*	Depending upon in what setting the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Non-Network Benefits are not available

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Cancer Treatment *This section refers to Cancer Treatment other than the Cancer Resource Services (CRS) program*	Depending upon in what setting the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon in what setting the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers.	Depending upon in what setting the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.	Depending upon in what setting the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.
Congenital Heart Disease (CHD) Surgeries Network and Non-Network Benefits under this section include only the inpatient facility charges for the Congenital Heart Disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Dental Services - Accident Only See Section 5, *Additional Coverage Details*, for limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Diabetes Services		
Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon in what setting the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.	Depending upon in what setting the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.
Diabetes Self-Management Items		
■ Diabetes equipment.	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.
■ Diabetes supplies.	Benefits for diabetes supplies will be provided under the Prescription Drug Program.	Benefits for diabetes supplies will be provided under the Prescription Drug Program.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Durable Medical Equipment (DME) See *Durable Medical Equipment* in Section 5, *Additional Coverage Details*, for limits. Notification is required for items that will cost more than $1,000 to purchase or rent.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Emergency Health Services - Outpatient	90% after you meet the Annual Deductible	Same as Network
Gender Dysphoria	Depending upon in what setting the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the *Schedule of Benefits* and in the Prescription Drug Program.	Depending upon in what setting the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the *Schedule of Benefits* and in the Prescription Drug Program.
Hearing Aids See Section 5, *Additional Coverage Details*, for limits.	*Hearing Aids* 90% after you meet the Annual Deductible *Hearing Aid Exams and Illness and Injury* 90% after you meet the Annual Deductible *Preventive/Routine Hearing Exam* 100%	70% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Home Health Care See Section 5, *Additional Coverage Details*, for limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Hospice Care	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Hospital - Inpatient Stay	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Infertility Services and Fertility Solutions (FS) Program See Section 5, *Additional Coverage Details*, for limits. This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.	Depending upon in what setting the Covered Health Service is provided, Benefits for Infertility Services will be the same as those stated under each Covered Health Service category in this section	Depending upon in what setting the Covered Health Service is provided, Benefits for Infertility Services will be the same as those stated under each Covered Health Service category in this section
Injections received in a Physician's Office	*Non-Preventive Injections and Travel-related Injections in a Physician's office* 90% after you meet the Annual Deductible *Preventive Injections* 100%	*Non-Preventive Injections* 70% after you meet the Annual Deductible *Travel-related Injections and Preventive Injections* Not Covered

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Kidney Resource Services *See Kidney Resource Services (KRS) in Section 5, Additional Coverage Details.* *This section refers to the Kidney Resource Services (KRS) program only.*	Depending upon in what setting the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Non-Network Benefits are not available .
Lab, X-Ray and Diagnostics - Outpatient		
■ Lab Testing - Outpatient.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ X-Ray and Other Diagnostic Testing - Outpatient.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Mental Health Services		
■ Inpatient.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Outpatient.	90% after you meet the Annual Deductible 90% for Partial Hospitalization/ Intensive Outpatient Treatment after you meet the Annual Deductible	70% after you meet the Annual Deductible 70% for Partial Hospitalization/ Intensive Outpatient Treatment after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient. ■ Outpatient.	90% after you meet the Annual Deductible 90% after you meet the Annual Deductible 90% for Partial Hospitalization/ Intensive Outpatient Treatment after you meet the Annual Deductible	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible 70% for Partial Hospitalization/ Intensive Outpatient Treatment after you meet the Annual Deductible
Nutritional Counseling See Section 5, *Additional Coverage Details* for limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Obesity Surgery Bariatric services must be received at a Designated Provider. See Section 5, *Additional Coverage Details* for limits.	Depending upon in what setting the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Non-Network Benefits are not available.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Oral Surgery/Wisdom Teeth Extraction or Orthognathic Surgery (Must be in a medical setting to be covered under the medical Plan)	Depending upon in what setting the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon in what setting the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Ostomy Supplies	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Pregnancy – Maternity Services When these services are performed for preventive purposes, Benefits are described in this section under Preventive Care Services.	Benefits will be the same as those stated under each Covered Health Service category in this section.	Benefits will be the same as those stated under each Covered Health Service category in this section.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Preventive Care Services		
■ Physician Office Services.	100%	Non-Network Benefits are not available except as stated in Section 5, *Additional Coverage Details* 70% after you meet the Annual Deductible
■ Lab, X-ray or Other Preventive Tests.	100%	Non-Network Benefits are not available except as stated in Section 5, *Additional Coverage Details* 70% after you meet the Annual Deductible
■ Breast Pumps.	100%	Non-Network Benefits are not available
Private Duty Nursing - Outpatient See Section 5, *Additional Coverage Details*, for limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Prosthetic Devices Notification is required for items that will cost more than $1,000 to purchase or rent.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Reconstructive Procedures	Depending upon in what setting the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon in what setting the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Rehabilitation Services - Outpatient Therapy See Section 5, *Additional Coverage Details*, for visit limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See Section 5, *Additional Coverage Details*, for limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Substance-Related and Addictive Disorders Services ■ Inpatient. ■ Outpatient.	90% after you meet the Annual Deductible 90% after you meet the Annual Deductible 90% for Partial Hospitalization/ Intensive Outpatient Treatment after you meet the Annual Deductible	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible 70% for Partial Hospitalization/ Intensive Outpatient Treatment after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Surgery - Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Teladoc Benefits are available only when services are delivered through a Teladoc provider.	90% after you meet the Annual Deductible	Same as Network
Telehealth Visits with providers using audio, video, or data communications billed by a Physician.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Temporomandibular Joint Dysfunction (TMJ)	Depending upon in what setting the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon in what setting the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Therapeutic Treatments - Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Transplantation Services Network Benefits must be received at a Designated Provider. Non-Network Benefits include services provided at a Network facility that is not a Designated Provider.	*Designated Transplant Facility:* Depending upon in what setting the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section. *Non-Designated Transplant Facility:* 70% after you meet the Annual Deductible	Non-Network Benefits are not available
Travel and Lodging (If services rendered by a Designated Provider) *Designated Provider requirement does not apply to Clinical Trials.*	For patient and companion(s) of patient undergoing cancer, Clinical Trials, obesity surgery services, Congenital Heart Disease treatment or transplant procedures	
Urgent Care Center Services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Vision Examinations See Section 5, *Additional Coverage Details*, for limits.	*Preventive* 100% *Non-Preventive - Medical, Illness or Injury* 90% after you meet the Annual Deductible *Vision Hardware* 90% after you meet the Annual Deductible	Non-Network Benefits for Preventive Eye Examinations are not available. 70% after you meet the Annual Deductible
Wigs See Section 5, *Additional Coverage Details*, for limits.	90% after you meet the Annual Deductible	90% after you meet the Annual Deductible

[1]Please obtain prior authorization from the Claims Administrator before receiving Covered Health Services, as described in Section 5, *Additional Coverage Details.*

SECTION 5 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to obtain prior authorization from the Claims Administrator before you receive them, and any reduction in Benefits that may apply if you do not call the Claims Administrator. ***Note***: Non-Network treatments/services that are deemed not Medically Necessary will not be covered. You will be responsible for paying all charges and no Benefits will be paid.

This section supplements the second table in Section 4, *Plan Highlights*.

While the table provides you with Benefit limitations along with Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization from the Claims Administrator as required. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 6, *Exclusions and Limitations*.

Acupuncture Services

The Plan pays for acupuncture services provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of their license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Chiropractor.
- Acupuncturist.

Any combination of Network and Non-Network Benefits is limited to 20 treatments per calendar year.

Did you know…
You generally pay less out-of-pocket when you use a Network provider?

Ambulance Services - Emergency Only

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 10, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UMR may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to rovide Emergency Health Services.

Ambulance Services - Non-Emergency

The Plan also covers non-Emergency transportation provided by a licensed professional ambulance (either ground or air ambulance, as UMR determines appropriate) between facilities when the transport is:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more Cost-Effective acute care facility.
- From an acute facility to a sub-acute setting.

Prior Authorization Requirement
This benefit requires prior authorization as follows: In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain prior authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction. As with all health care services, the use of ambulance services in a non-emergent context is only a Covered Health Service if it is Medically Necessary.

Cancer Resource Services (CRS)

Cancer Resource Services (CRS) consists of Optum Centers of Excellence (COE) Network access.

If a Covered Person chooses to seek services at Roswell Park Cancer, the Covered Person must contact Accolade at 844-287-3861 or the services will be considered out-of-network.

If a Covered Person chooses to seek services at Huntsman Cancer Institute at the University of Utah in Salt Lake City, the Covered Person must contact Accolade at 844-287-3861 or services will be considered out-of-network.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- *Physician's Office Services.*
- *Physician Fees for Surgical and Medical Services.*
- *Scopic Procedures - Outpatient Diagnostic and Therapeutic.*
- *Therapeutic Treatments - Outpatient.*
- *Hospital - Inpatient Stay.*
- *Surgery - Outpatient.*

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UMR determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UMR determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as UMR determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for qualifying Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with UMR's medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease, musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying Clinical Trial is a Phase I, Phase II, or Phase III Clinical Trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI)*).
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UMR may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises. If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a $500 reduction.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

Accolade has specific guidelines regarding Benefits for CHD services. Contact Accolade at the number on your ID card for information about these guidelines.

The Plan pays Benefits for CHD services ordered by a Physician and received at a facility participating in the CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

Benefits are available for the following CHD services:

- Outpatient diagnostic testing.
- Evaluation.
- Surgical interventions.
- Interventional cardiac catheterizations (insertion of a tubular device in the heart).
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by Optum to be proven procedures for the involved diagnoses. Contact Accolade at 844-287-3861 before receiving care for information about CHD services. More information is also available at **member.accolade.com**.

If you receive CHD services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- *Physician's Office Services.*
- *Physician Fees for Surgical and Medical Services.*
- *Scopic Procedures - Outpatient Diagnostic and Therapeutic.*
- *Therapeutic Treatments - Outpatient.*
- *Hospital - Inpatient Stay.*
- *Surgery - Outpatient.*

To receive Benefits under the CHD program, you must contact Accolade at 844-287-3861 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if Accolade provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Note: The services described under the *Travel and Lodging Assistance Program* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from Accolade as soon as the possibility of a Congenital Heart Disease (CHD) surgery arises. If you do not obtain prior authorization from Accolade as required, Benefits will be subject to a $500 reduction.

COVID-19 Services

Coverage for COVID-19 diagnostic testing, vaccines and ancillary services directly related to such covered services will be provided in accordance with applicable legal requirements.

Dental Services

Dental services are covered by the Plan when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- Dental services related to medical transplant procedures.
- Initiation of immunosuppressive (medication used to reduce inflammation and suppress the immune system).
- Direct treatment of acute traumatic Injury, cancer or cleft lip/palate.

Benefits are available only for treatment of a sound, natural tooth. Before the Plan will cover treatment of an injured tooth, the dentist must certify that the tooth is virgin or unrestored, or that it:

- Has no decay.
- Has no filling on more than two surfaces.

- Has no gum disease associated with bone loss.
- Has no root canal therapy.
- Is not a dental implant.
- Functions normally in chewing and speech.

Dental services to repair the damage caused by accidental Injury must conform to the following time-frames: Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 3 months of coverage under the Plan.

Oral Surgery/Wisdom Teeth Removal

Oral surgery and extraction of impacted wisdom teeth when deemed Medically Necessary. Anesthesia is covered for wisdom tooth extraction and oral surgery.

Orthognathic Surgery

Orthognathic surgery is covered in the following situations: A jaw deformity resulting from facial trauma or cancer or a skeletal anomaly of either the maxilla or mandible, that demonstrates a functional medical impairment such as one of the following: Inability to incise solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, speech impediment determined to be due to the jaw deformity or malnutrition and weight loss due to inadequate intake secondary to the jaw deformity. Treatment of malocclusion is dental and therefore not a Covered Health Service.

Hospitalization and Anesthesia

Hospitalization and anesthesia coverage is provided for any dental services that must be performed by a Doctor of Dental Surgery, "D.D.S." or a Doctor of Medical Dentistry; "D.M.D." for the treatment of a child or disabled person who is unable to cooperate in their care as determined by the Claims Administrator.

Cleft Lip/Palate

Coverage for orthodontic services, oral surgery, and otologic, audiological and speech therapy/language treatment for an enrolled Dependent child in connection with cleft lip or cleft palate, or both. Services must be provided by or under the direction of a Physician. Coverage to age 26. Network providers are required for Network coverage.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment (DME). Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the prescription drug Plan.

Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment* in this section.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining any DME for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a $500 reduction.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.
- Durable enough to withstand repeated use.

Benefits under this section include Durable Medical Equipment provided to you by a Physician. If more than one piece of DME can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Negative pressure wound therapy pumps (wound vacuums).
- Burn garments.

- Insulin pumps and all related necessary supplies as described under Diabetes Services in this section.
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage.
- Cranial helmets - adjustable helmets used for treatment of plagiocephaly (including plagiocephaly caused by torticollis) for children ages 3 – 18 months. For children under 6 months of age, coverage must be preceded by two months of conservative repositioning therapy.
- Custom molded shoe orthotics when prescribed by Physician. This includes shoe inserts, arch supports, shoes (standard or custom) and lifts and wedges; and
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

Note: DME is different from prosthetic devices - see *Prosthetic Devices* in this section.

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan. Benefits for repair/replacement are limited to once every three years.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three calendar years.

At UMR's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before obtaining any DME or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a $500 reduction.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within 24 hours of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. Eligible Expenses will be determined as described under *Eligible Expenses* in Section 2, *How the Plan Works*.

Benefits under this section are available for services to treat a condition that does not meet the definition of an Emergency.

Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify the Claims Administrator within 24 hours or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

Gender Dysphoria

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

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided as described under *Mental Health Services* in your Benefits Summary.
- Cross-sex hormone therapy:

- Cross-sex hormone therapy administered by a medical provider.

- 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 Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person 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 Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person 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).

The treatment Plan is based on identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

Prior Authorization Requirement for Surgical Treatment
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of surgery arises. If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a $500 reduction.

Prior Authorization Requirement for Non-Surgical Treatment
Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Service category.

Hearing Aids

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

The Plan pays Benefits for external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. Benefits for cochlear implantation are provided under the applicable medical / surgical Benefit categories in this Benefit Summary. See *Hospital – Inpatient Stay*, *Rehabilitation Services – Outpatient Therapy* and *Surgery – Outpatient* in this section.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.

- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Any combination of Network Benefits and Non-Network Benefits for device/fitting/exam is limited to $1,500 per hearing impaired ear and a single purchase (including repair/replacement) per hearing impaired ear every 36 months from the last date of service. Hearing aid batteries are not covered.

This Plan also includes a benefit that allows Covered Persons to access discounted hearing aids and related testing and fitting. This benefit is being offered under the Plan by UnitedHealthcare Hearing.

UnitedHealthcare Hearing provides a full range of hearing health Benefits that deliver value, choice, and a positive experience.

UnitedHealthcare Hearing offers:

- Name-brand and private-labeled hearing aids from major manufacturers at discounted prices.
- Access to a Network of credentialed hearing professionals at more than 5,000 locations nationwide.
- Convenient ordering with hearing aids available in person or through home delivery.

How To Use This Hearing Benefit:

- Contact UnitedHealthcare Hearing at 1-855-523-9355, between 8:00 a.m. and 8:00 p.m. Central Time Monday through Friday, or visit **uhchearing.com** to learn more about the ordering process and for a referral to a UnitedHealthcare Hearing provider location (if a hearing test is needed).
- Receive a hearing test by a UnitedHealthcare Hearing provider. During the appointment, you will decide if you would like to have your hearing aids fitted in person with your hearing provider or to have your hearing aids delivered directly to your home (for select hearing aid models only). A broad selection of name-brand and private-labeled hearing aids is available.
- If you choose to purchase hearing aids through the UnitedHealthcare Hearing provider, the hearing aids will be ordered by the provider and sent directly to the provider's office. You will be fitted with the hearing aid(s) by the local provider. If you choose home delivery, the hearing aids will be sent directly to your home within 5-10 business days from the order date.

In the event that you have questions or complaints about the hearing aid products or services offered under the Plan, contact UnitedHealthcare Hearing at 1-855-523-9355 or visit **uhchearing.com**.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator for cochlear implants before receiving services. If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a $500 reduction.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Not considered Custodial Care, as defined in Section 10, Glossary.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 10, *Glossary* for the definition of Skilled Care.

The Claims Administrator will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Any combination of Network Benefits and Non-Network Benefits is limited to 200 visits per calendar year. One visit equals four hours of Skilled Care services. Home Health and Private Duty Nursing are combined for the 200 visit annual limit. Home Infusions not counted toward calendar year visit limit.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before receiving services, including Private Duty Nursing, or as soon as is reasonably possible. If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a $500 reduction.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a $500 reduction.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Prior Authorization Requirement
For Non-Network Benefits, for:
- A scheduled admission, you must obtain prior authorization from the Claims Administrator 24 hours before admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.

If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a $500 reduction.

Infertility Services and the Fertility Solutions (FS) Program

The Plan pays Benefits for Infertility Services (as defined below) when provided by or under the direction of a Physician, after meeting the following requirements:

- The Covered Person must meet the definition of infertility. For purposes of this Plan, a Covered Person will meet the definition of infertility by meeting one of the following criteria:

- have failed to achieve or maintain Pregnancy after twelve months of regular, unprotected heterosexual intercourse if the woman is under age 35, or after six months if the woman is age 35 or older; or
- have failed to achieve or maintain a Pregnancy following six treatment cycles of medically supervised donor insemination; or
- have failed to achieve or maintain a Pregnancy due to impotence/sexual dysfunction; or
- have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization; or
- have diagnosis of a male factor causing infertility (e.g. treatment of sperm abnormalities including the surgical recovery of sperm).

Note: Any infertility waiting period described above is waived when Covered Person has a known infertility factor, including but not limited to tubal disease, endometriosis, ovulatory disorder, or diminished ovarian reserve.

- The Covered Person must meet the following age requirements:
  - be under age 44, if female and using own oocytes (eggs).
  - be under age 55, if female and using donor oocytes (eggs).

  Note: For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.

Benefits under this section are limited to the following ("Infertility Services"):

- In vitro fertilization (IVF) including: egg/oocyte retrieval, embryo transfer, intracytoplasmic sperm injection (ICSI), assisted hatching, cryopreservation and storage of embryos for 12 months, embryo biopsy for PGT-M or PGT-SR;
- Frozen embryo transfer cycle, including the associated cryopreservation and storage of embryos for 12 months;
- Ovulation induction and controlled ovarian stimulation;
- Insemination procedures: Artificial Insemination (AI) and Intrauterine Insemination (IUI);
- Fertility surgical procedures; and
- Fertility preservation services - when planned cancer or other medical treatment for a Covered Person is likely to produce infertility/sterility: coverage is limited to collection of sperm, cryopreservation of sperm, ovulation inductions and retrieval of eggs, oocyte cryopreservation, in vitro fertilization, embryo cryopreservation and storage costs up to one year. (Note: In this circumstance, the requirements regarding definition of infertility outlined above are waived for the Covered Person, but the age requirements must still be met.)

  Note: If a Covered Person is using donor oocytes or sperm for treatment, the Plan will cover the medical expenses of the donor associated with collection and preparation of ovum and/or sperm, and the medications associated with the collection and preparation of ovum and/or sperm. The Plan will not pay for donor charges associated with compensation or administrative services.

Note: Benefits for Physician office visits and consultations, diagnostic tests and injectables administered in a Physician's office are covered as described under *Physician's Office Services - Sickness and Injury* in this summary.

Any combination of Network Benefits and Non-Network Benefits for Infertility Services received is limited to $30,000 per Covered Person during the entire period you are covered under the Plan. There is a separate $15,000 prescription drug lifetime maximum, under the Prescription Drug Program.

Prior to receiving infertility services and treatment, contact Accolade to see if you could benefit from enrollment in the Fertility Solutions Program. The Fertility Solutions (FS) Program is available to Covered Persons and provides education, counseling, infertility management and access to a national Network of premier infertility treatment clinics.

To enroll in the Fertility Services Program, you or a covered Dependent may:

- Be referred to FS by Accolade.
- Call the telephone number on your ID card.

Prior Authorization Requirement
For Non-Network Benefits for Infertility Services, you must obtain prior authorization from the Claims Administrator before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

Injections received in a Physician's Office

The Plan pays for Benefits for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy or Network immunizations for travel. Botulinum Type A is proven treatment and is covered for certain conditions.

Kidney Resource Services (KRS)

Kidney Resource Services (KRS) provides access to a preferred provider dialysis Network and support from UMR Case Management by collaborating with the Covered Person to delay the progression of the disease to renal failure.

UMR Case Management End-Stage Renal Disease (ESRD) specialty nurses focus on clinical support and treatments.

If a Covered Person chooses to seek services at KRS preferred provider, the Covered Person must contact Accolade at 844-287-3861.

The Plan pays Benefits for both chronic kidney disease and End Stage Renal Disease (ESRD) provided by Designated Providers participating in the Kidney Resource Services (KRS) program. Designated Provider is defined in Section 10, *Glossary*.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- *Physician's Office Services.*
- *Physician Fees for Surgical and Medical Services.*
- *Scopic Procedures - Outpatient Diagnostic and Therapeutic.*
- *Therapeutic Treatments - Outpatient.*
- *Hospital - Inpatient Stay.*
- *Surgery - Outpatient.*

To receive Benefits under the KRS program, you must contact Accolade prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if Accolade provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include:

- Lab and radiology/X-ray.
- Mammography.
- Sleep studies.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Prior Authorization Requirement
For Non-Network Benefits for sleep studies, including sleep study related lab, x-ray and diagnostics, you must obtain prior authorization from the Claims Administrator before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Prior Authorization Requirement
For Non-Network Benefits for Breast MRI when related to a 4D mammogram for a medical condition, you must obtain prior authorization from the Claims Administrator before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

Mental Health Services Provided through Optum Behavioral Health

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

- Bereavement counseling (up to 6 months after the death of an immediate family member, as defined under Fidelity's bereavement policy).
- Diagnosis and treatment for gender identity disorder/dysphoria as it relates to behavioral health; and
- Attention Deficit Hyperactivity Disorder (ADHD) testing and treatment for adults and children.
- Autism Spectrum Disorder services, see *Neurobiological Disorders - Autism Spectrum Disorder Services*.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact Accolade for referrals to providers and coordination of care.

Prior Authorization Requirement
Non-Network Benefits for:

- A scheduled admission for Mental Health Services (including services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator 24 hours before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management, you must obtain prior authorization for Non-Network Benefits before services are received.

If you fail to obtain prior authorization from or provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as required, Benefits will be subject to a $500 reduction.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a *Board Certified Applied Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient Treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Provider-based case management services.
- Assessment and diagnosis completed by a medical Physician, psychiatrist or someone with a MD licensure.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact Accolade for referrals to providers and coordination of care.

The Autism and Behavioral Needs Navigator Program

The Autism and Behavioral Needs Navigator Program uses a wide range of approaches to assess and respond to the complexities of families of individuals with special needs. A master's-prepared, licensed clinician acts as a navigator and coach to guide families through the confusing maze of social service, medical, and education systems.

After an initial assessment, the navigator works with other benefit programs offered to families to ensure a seamless integration of services and resources while educating and empowering the family.

Based on a family assessment this will not be a Benefits based program, rather a "resource" that will help work with Covered Persons regarding their specific needs and questions related to a certain diagnosis/need.

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility), you must obtain authorization prior to the admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.
- In addition for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA).*

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a $500 reduction.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by a Registered Dietitian, Physician, Nurse Practitioner or Nurse.

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Some examples of such medical conditions include, but are not limited to:

- Coronary artery disease.
- Congestive heart failure.
- Severe obstructive airway disease.
- Gout (a form of arthritis).
- Renal failure.
- Phenylketonuria (a genetic disorder diagnosed at infancy).
- Hyperlipidemia (excess of fatty substances in the blood).

Benefits are limited to 24 individual sessions per calendar year. This limit applies to non-preventive nutritional counseling services only.

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services* in this section.

Enteral Feedings, Nutritional Supplements, Vitamins, and Electrolytes

The Plan will pay for enteral feedings, nutritional supplements, vitamins, and electrolytes required for any of the following conditions:

- Specific inborn errors of metabolism (including, but not limited to phenylketonuria - PKU, tyrosinemia, homocystinuria, maple syrup urine disease, propionic academia, or methylmalonic acidemial, or to protect the fetus of a pregnant woman with PKU);
- Malabsorption caused by disorders affecting the absorptive surface, functional length, gastrointestinal tract motility (including, but not limited to Crohn's disease, ulcerative colitis, gastroesophageal reflux, chronic intestinal pseudo-obstruction, inherited diseases of amino and/or organic acids); or
- Central nervous system/neuromuscular condition that significantly impairs the ability to safely ingest oral nutrition.

Obesity Surgery

The Plan covers surgical treatment of morbid obesity (including lap band) provided by or under the direction of a Physician provided either of the following is true:

- You have a minimum Body Mass Index (BMI) of 40;
- You have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity;
- The surgery is performed at a Bariatric Resource Service (BRS) Designated Provider by a Network surgeon even if there are no BRS Designated Providers near you.

In addition to meeting the above criteria, the following must also be true:

- You are over the age of 18;
- You have documentation of 6-month Physician supervised diet within the last two years; and
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation within 12 months of surgery.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 10, *Glossary* and are not Experimental or Investigational or Unproven Services.

You will have access to a certain Network of Designated Providers and Physicians participating in the Bariatric Resource Services (BRS) program, as defined in Section 10, *Glossary*, for obesity surgery services.

For obesity surgery services to be considered Covered Health Services under the BRS program, you must contact Bariatric Resource Services and speak with a nurse consultant prior to receiving services. You can contact Accolade by calling toll-free at 1-844-287-3861.

Note: The services described under the *Travel and Lodging Assistance Program* are Covered Health Services only in connection with obesity-related services received at a Designated Provider.

Prior Authorization Requirement
All authorization information and enrollment for bariatric surgery must be initiated through OptumHealth's Bariatric Resource Services (BRS) Program. Covered participants seeking coverage for bariatric surgery must obtain prior authorization from Accolade by calling 1-844-287-3861 to enroll in the program as soon as the possibility of a bariatric surgery procedure arises (and before the time a pre-surgical evaluation is performed) at a bariatric surgery center. If prior authorization from BRS is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Sickness or Injury.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by UMR.

Benefits for preventive services are described under *Preventive Care Services* in this section.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as is reasonably possible before Genetic Testing - BRCA. If prior authorization is not obtained as required, Benefits will be subject to a $500 reduction.

Please Note
Your Physician does not have a copy of your Benefits Summary, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the *Newborns' and Mothers' Health Protection Act of 1996* which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Accolade offers Pregnancy support services to engage with expectant mothers early in their Pregnancy with a goal of helping a Covered Person achieve fewer preterm births and low birth weight infants thereby reducing Pregnancy-related costs. Contact Accolade at 844-287-3861 to participate.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.

Newborn Enrollment
For your newborn to be covered under the Plan, you must enroll your newborn by logging on to NetBenefits or contacting the Fidelity Benefits Center at 800-835-5099 within 31 days of the birth.

Preventive Care Services

The Plan pays Benefits for preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.*
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Preventive care Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting or purchasing one breast pump per Pregnancy in conjunction with childbirth. Breast pumps rentals must be ordered by or provided by a Physician. Benefits for breast pump purchases are only available if breast pumps are obtained from a Network DME provider or Physician. You can obtain additional information on how to access Benefits for breast pumps by going to **member.accolade.com** or by calling the number on your ID card. These Benefits are described under Section 4, *Plan Highlights*, under *Covered Health Services*.

If more than one breast pump can meet your needs, Benefits are available only for the most Cost Effective pump. UMR will determine the following:

- Which pump is the most Cost Effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

In addition to the services listed above, this preventive care benefit includes:

- Physical exams, no limit to age 18, and once per calendar year from age 18 (Network only);
- Routine lab, tests, and x-rays at appropriate ages (Network only);
- Preventive screenings, including autism screenings (Network and non-Network);
- Preventive counseling for alcohol/substance use disorder, obesity, diet and nutrition (Network and non-Network);
- Diagnostic consults to prevent disease and detect abnormalities (Network and non-Network);
- Diagnostic radiology and nuclear imaging procedures to screen for abnormalities (Network and non-Network);
- Breast cancer screening mammogram and 3D mammograms from age 40 and Genetic Testing (Network and non-Network);
- Tests to support cardiovascular health (Network and non-Network);
- Preventive colonoscopies to age 50 due to family history, or from age 50 to 75 for preventive reasons (Network only);
- Preventive sigmoidoscopies and similar routine surgical procedures performed for preventive reasons from age 50 to age 75 (Network only);
- Preventive hearing exams (Network only);
- All routine immunizations are covered (Network only, except as required by law);
- Cervical cancer screening and diagnosis covered regardless of age and/or sexual history once per calendar year (Network and non-Network). The only requirement is the presence of a cervix;
- OB/Gyn and Prenatal (Network and non-Network);
- Cervarix is covered for females only (Network and non-Network);
- Gardasil is covered for females and males (Network and non-Network);
- Tobacco Cessation services covered through Optum: Preventive Care as required by applicable law, including (i)tobacco screening for adults; (ii) tobacco use behavioral interventions for adults, school-aged children and adolescents, and (iii) FDA-approved

pharmacotherapy (provided through the prescription drug program) for non-pregnant adults who use tobacco (Network and non-Network); and

- Expanded Preventive care services for chronic medical conditions: blood pressure monitor for the diagnosis of hypertension; retinopathy screening, glucometer and hemoglobin A1C testing for the diagnosis of diabetes; international normalized ratio (INR) testing for the diagnosis of liver disease and/or bleeding disorders; and low-density lipoprotein (LDL) testing for the diagnosis of heart disease (Network and non-Network).

Note: Where a Preventive Care Service listed above provides for a specified minimum age and is received by a Covered Person prior to attaining that minimum age, the Plan will pay the claim as a diagnostic service, after the Deductible is met.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services.

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Any combination of Network Benefits and Non-Network Benefits is limited to 200 visits per calendar year. Home Health and Private Duty Nursing are combined for the 200 visit annual limit.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization for Private Duty Nursing from the Claims Administrator before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

Prosthetic Devices

Benefits are paid by the Plan for external prosthetic devices that replace a limb or body part limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and noses.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.
- Benefits are limited to a single purchase of each type of prosthetic device every five calendar years.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining prosthetic devices that exceed $1,000 in cost per device. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive Procedures include surgery or other procedures which are associated with a Sickness, Injury or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed a mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact Accolade at the number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic Procedures are excluded from coverage. Procedures

that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 10, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of a Sickness, Injury or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedure.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before a scheduled Reconstructive Procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Vision therapy.
- Cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident.
- Pulmonary rehabilitation.
- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under *Home Health Care*. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits under this section are not available for maintenance/preventive treatment.

For outpatient rehabilitation services for speech therapy, the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the

Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices*.

The Plan also provides coverage for speech therapy for stuttering that results from an Injury or illness.

Pervasive Developmental Disorders, including but not limited to Autistic Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, Rett's Disorder, and Pervasive Development Disorder not Otherwise Specified/Atypical Autism, will no longer be exclusions. A Covered Person diagnosed with a pervasive developmental disorder will be eligible to receive coverage under the Plan subject to the standard limits and requirements.

Early intervention is covered when in conjunction with Physical therapy, Occupational Therapy and Speech Therapy. Services must be Medically Necessary.

Please note that the Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Benefits are limited to:

- 100 visits per calendar year for physical and occupational therapy combined, except when additional visits are Medically Necessary and in the case of visits for a behavioral health condition.
- 52 visits per calendar year for speech therapy unless Medically Necessary and except in the case of visits for a behavioral health condition.
- 20 visit lifetime maximum limit for eye exercise or vision therapy.
- 20 visits per calendar year for Manipulative Treatment.
- Unlimited visits per calendar year for pulmonary rehabilitation therapy.
- Unlimited visits per calendar year for cardiac rehabilitation therapy.
- Unlimited visits per calendar year for cognitive rehabilitation therapy.
- Unlimited visits per calendar year for post-cochlear implant aural therapy.

These visit limits apply to Network Benefits and Non-Network Benefits combined. Coverage may be available for additional visits if the Claims Administrator, after review of the participant's medical condition, determines that additional visits are necessary and medically appropriate.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and diagnostic endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UMR will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost-Effective alternative to an Inpatient Stay in a Hospital.
- You will receive Skilled Care services that are not primarily Custodial Care.

Skilled Care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- You are expected to improve to a predictable level of recovery.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 10, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to 100 days per calendar year.

Prior Authorization Requirement
For Non-Network Benefits for a scheduled admission, you must obtain prior authorization from the Claims Administrator before admission, or as soon as is reasonably possible for non-scheduled admissions. If authorization is not obtained as required, or notification is not provided, Benefits will be subject to a $500 reduction.

Specialty Medications

The Plan pays for specialty injectable medications that are:

- Used to treat complex, chronic or rare medical conditions (e.g. cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis).
- Typically administered by injection or infusion.
- Often required to have special handling (e.g. refrigeration) and ongoing clinical monitoring.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before obtaining these specialty injectable medications; Brineura; Spinraza, Exondys; Lumizyme; Luxtuma; Soliris CAR-T drugs; Kymriah; Yescarta. If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a $500 reduction.

Specialty injectable medications refers to a prescription drug used to treat complex, chronic or rare medical conditions (e.g. cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Specialty injectable medications often require special handling (e.g. refrigeration) and ongoing clinical monitoring.

Substance-Related and Addictive Disorders Services Provided through Optum Behavioral Health

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

There may be significant cost to you if a Non-Network facility or provider is utilized, as there may be services that are not covered under the Plan.

You are encouraged to contact Accolade for referrals to providers and coordination of care.

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator prior to the admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; Opioid Treatment program; Ambulatory detox; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a $500 reduction.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Prior Authorization Requirement
For Non-Network Benefits for varicose vein ablative and stripping and ligation procedures, sleep apnea surgery, cochlear implants, orthognathic condition surgeries to correct skeletal mismatches of the jaw, arthroplasty shoulder replacement surgery, bone growth stimulator and other bone or soft tissue healing and fusion enhancement products, articular cartilage repair (allograft or autograft), proton beam therapy for definitive therapy (covered for the treatment of prostate cancer), spinal stimulator for the treatment of chronic intractable pain, including implanted peripheral nerve stimulators and central nervous system stimulators, spinal fusion surgery, vagus nerve stimulation for the treatment of refractory epilepsy and partial onset seizures, ventricular assist devices to assist or augment the ability of a damaged or weakened native heart to pump blood, you must obtain prior authorization from the Claims Administrator before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be subject to a $500 reduction.

Teladoc Services

Note: Teladoc Services are subject to state availability. Access to telephonic or video-based consultations may be restricted in some states. The Teladoc general medicine, dermatology and behavioral health Networks are distinct from other Networks associated with Your medical Plan.

Teladoc Services allow Covered Persons of all ages to receive telephone or web-based video consultations with Physicians for routine primary medical diagnoses. Teladoc may be used:

- When immediate care is needed.
- When considering the ER or Urgent Care Center for non-Emergency issues.
- When You are on vacation or on a business trip.

Teladoc can be used for the following types of conditions:

- General medicine, including, but not limited to:
  - Colds and flu.
  - Allergies.
  - Bronchitis.
  - Pink eye.
  - Upper respiratory infections.
- A refill of a recurring Prescription.
- Pediatric care.
- Non-Emergency medical assistance.

A medical history disclosure form must be completed that will serve as an electronic medical record for consulting Physicians. This form can be completed via the Teladoc website, via the call center, or via the Teladoc mobile app. Once enrolled, a Covered Person may phone 1-800-TELADOC (1-800-835-2362) and request a consultation with a Physician. A Physician will then return the Covered Person's phone call. If a web-based video consultation is requested, the consultation will be scheduled and an appointment reminder notification will be sent prior to the appointed time. If necessary, the Physician will write a prescription, which will be called in to a pharmacy of choice.

Teladoc may not be used for:

- Drug Enforcement Agency-controlled Prescriptions.
- Charges for telephone or online consultations with Physicians and/or other providers who are not contracted through Teladoc.
- Consultations in states/jurisdictions where not available due to regulations or interpretations affecting the practice of telemedicine for medical or dermatology or behavior health conditions.

Teladoc Dermatology Services

In addition to receiving care for general medical conditions, access to dermatology services is also available.

Dermatologists provide dermatology consultations through an online message center using store-and-forward technology in the dermatology service area. The dermatology program offers Covered Persons the ability to upload photographs of their dermatological conditions to licensed dermatologists, who provide treatment and prescription medication, when appropriate. The dermatologists are selected and engaged to provide dermatological assessments in accordance with standard dermatology protocols and guidelines that are tailored to the telehealth industry.

In order to receive dermatology consultations, Teladoc's requirement for access to the general medicine program must be completed, including the medical history disclosure form. A comprehensive Dermatology Intake Form must also be completed prior to receiving a dermatology consultation that consists of a Dermatology History section and an intake form for the condition for which the Covered Person is seeking treatment describing the area of concern. This medical history and intake form may be completed either online or by telephone with a designated dermatology representative. Additionally, the Covered Person must upload at least three images of the Covered Person's condition prior to communicating with a dermatologist. If the Dermatology Intake Form is not completed or the required number of images are not uploaded, the Covered Person will not have access to the dermatologists.

More than one dermatology consultation can be requested at any given time. Dermatology consultations are not intended to be provided in Emergency situations.

Teladoc Behavioral Health

Teladoc Behavioral Health includes access to behavioral health Providers who provide behavioral health consultations by telephone or video conference. The Behavioral Health Program offers ongoing access to behavioral diagnostic services, talk therapy, and prescription medication management, when appropriate. The behavioral health Providers are selected and engaged to provide behavioral health clinical intake assessments in accordance with behavioral health protocols and guidelines that are tailored to the telehealth industry.

In order to receive a behavioral health consultation under this program, the Covered Person must complete a Medical History Disclosure and an assessment that is specific to the Behavioral Health Program. This disclosure may be completed either online or by telephone with a designated Behavioral Health Program representative. In addition, the Covered Person must also agree to Teladoc's Informed Patient Consent and Release Form confirming an understanding that the behavioral health Provider is not obligated to accept that as a patient. If the Medical History Disclosure is not completed, the Covered Person will not have access to the behavioral health providers through Teladoc Behavioral Health.

Scheduling: Teladoc will provide information identifying each behavioral health provider's licensure, specialties, gender, and language, and will provide sufficient biographical information on each behavioral health provider to allow the Covered Person to choose the provider from whom the Covered Person wishes to receive treatment. Consultations may be scheduled through either Teladoc's website or the mobile platform. When scheduling a subsequent consultation, the Covered Person may choose to receive the consultation from the same provider or from a different behavioral health provider. There are no limitations on the number of behavioral health consultations received under Teladoc Behavioral Health.

Individual Sessions: The initial behavioral health consultation is expected to be 45 minutes in length, on average followed by subsequent psychiatric visits that will be shorter in length. At the beginning of the behavioral health consultation, the Covered Person will be required to complete a brief intake assessment before proceeding with the session. A behavioral health provider may determine that the treatment of a particular behavioral health issue would be managed more appropriately through in-person therapy. In such a case, the behavioral health provider will encourage the Covered Person to make an appointment for an in-person visit. Teladoc's nurse team will make proactive efforts to contact the Covered Person by telephone after the second and sixth consultations to assess the effectiveness of the treatment.

Unlike the consultations provided under the general medicine program, the behavioral health consultations under Teladoc Behavioral Health:

- Are not accessible 24 hours per day, 365 days per year. Rather, a Covered Person must schedule a behavioral health consultation with a behavioral health provider and the consultation must occur within a time period for which the behavioral health provider is scheduled to support the Teladoc Behavioral Health.

- Are not intended to be cross-coverage consultations. Rather, Teladoc Behavioral Health is designed to make behavioral health providers available by telephone or video conference even when another behavioral health counselor is available for an in-person visit.
- Are not intended to be provided in Emergency situations.
- Are currently not available to Covered Persons who are minors.

Telehealth

The Plan covers services for Telehealth. Telehealth means the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications that is billed by a Physician.

Temporomandibular Joint Dysfunction (TMJ)

The Plan covers services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

The Plan provides coverage for physical therapy, surgery, MRI, simple x-rays to the head, neck and temporomandibular joint. The Plan excludes coverage of appliances, including, but not limited to, splints, study models, bite plates, tens units, panoramic x-rays, and ultrasounds for TMJ dysfunction.

Diagnosis: Examination, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital - Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Prior Authorization Requirement
For Non-Network Benefits for the following outpatient therapeutic services you must obtain prior authorization from the Claims Administrator before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy and MR-guided focused ultrasound. If you fail to obtain prior authorization from the Claims Administrator, as required, Benefits will be subject to a $500 reduction.

Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

For Network Benefits, transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures must be received at a Designated Provider to receive the highest benefit level. Transplantation services provided

by a non-Designated Provider are covered when performed in Network. Transplantation services provided by a non-Network, non-Designated Provider are not available.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator for a cornea transplant nor is the cornea transplant required to be performed at a Designated Provider.

Note: The services described under the *Travel and Lodging Assistance Program* are Covered Health Services only in connection with transplant services received at a Designated Provider.

Prior Authorization Requirement
For Network Benefits you must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Provider, Network Benefits will not be paid. Non-Network Benefits will apply.

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). For Non-Network Benefits, if you don't obtain prior authorization from the Claims Administrator, Benefits will be subject to a $500 reduction.

Support in the event of serious illness
If you or a covered family member has cancer or needs an organ or bone marrow transplant, Accolade can put you in touch with quality treatment centers around the country.

Travel and Lodging Assistance Program

Your Plan Sponsor may provide you with travel and lodging assistance. Travel and lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the travel and lodging assistance program, please call Accolade at 1-844-287-3861.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided the Covered Person is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and their companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The Bariatric Resource Services (BRS) program offers an overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.
- The Cancer Resource Services (CRS) program offers an overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.
- The Congenital Heart Disease (CHD) program offers an overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.
- The Transplant program provides a separate maximum of $25,000 per Covered Person per procedure for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.
- The Clinical Trials benefit provides a separate maximum of $25,000 per Covered Person per procedure for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.
- The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $125.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $250.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.

- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 10, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services*.

Vision Examinations

The Plan pays Benefits for:

- Vision screenings, which could be performed as part of an annual physical examination in a provider's office (vision screenings do not include refractive examinations to detect vision impairment).
- One routine vision exam, including refraction and glaucoma testing, to detect vision impairment by a provider in the provider's office every calendar year.

Please note that Benefits are available for charges connected to the purchase or fitting of eyeglasses or contact lenses required as a result of an accident or to those Covered Persons who require eyeglasses or contacts after cataract surgery.

Wigs

The Plan pays Benefits for wigs or toupees for hair loss resulting from treatment of a malignancy or permanent loss of hair from an accidental Injury or medical condition. Hair

transplants, hair weaving or any drug if such drug is used in conjunction with baldness is not covered.

Any combination of Network and Non-Network Benefits for wigs is limited to $1,000 per calendar year.

SECTION 6 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:
- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 5, *Additional Coverage Details*.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 5, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 4, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 4, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the Benefits Summary says "this includes," or "including but not limited to," it is not UMR's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the Benefits Summary specifically states that the list "is limited to."

Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 5, *Additional Coverage Details*.

Comfort and Convenience

Supplies, equipment and similar incidentals for personal comfort. Examples include:

1. Television.
2. Telephone.
3. Air conditioners.

4. Beauty/barber service.

5. Guest service.

6. Air purifiers and filters.

7. Batteries and battery chargers.

8. Dehumidifiers and humidifiers.

9. Ergonomically correct chairs.

10. Non-Hospital beds and comfort beds.

11. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 5, *Additional Coverage Details.*

12. Home remodeling to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only, Oral Surgery/Wisdom Teeth Removal and Orthognathic Surgery* in Section 5, *Additional Coverage Details.*

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 5, *Additional Coverage Details.*

2. Preventive care, diagnosis, treatment of the teeth or gums. Examples include:

   - Extractions (not including wisdom teeth), restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to Benefits described in Section 5, *Additional Coverage Details* under the heading *Dental Services - Accident only, Oral Surgery/Wisdom Teeth Removal and Orthognathic Surgery*.

3. Dental implants and braces.

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only*, *Oral Surgery/Wisdom Teeth Removal and Orthognathic Surgery* in Section 5, *Additional Coverage Details*.

4. Dental braces (orthodontics).

5. Treatment of malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.

2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UMR), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

   This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 5, *Additional Coverage Details*.

Foot Care

1. Routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 5, *Additional Coverage Details*. Routine foot care services that are not covered include:

   - Cutting or removal of corns and calluses.
   - Nail trimming or cutting.

- Debriding (removal of dead skin or underlying tissue).

2. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

3. Treatment of flat feet.

4. Shoe inserts.

5. Arch supports.

6. Shoes (standard or custom), lifts and wedges.

7. Shoe orthotics, unless they are custom molded.

Gender Dysphoria Cosmetic Treatment

1. Cosmetic Procedures, including the following:

   - Abdominoplasty.
   - Blepharoplasty.
   - Breast enlargement, including augmentation mammoplasty and breast implants.
   - Body contouring, such as lipoplasty.
   - Brow lift.
   - Calf implants.
   - Cheek, chin, and nose implants.
   - Injection of fillers or neurotoxins.
   - Face lift, forehead lift, or neck tightening.
   - Facial bone remodeling for facial feminizations.
   - Hair removal.
   - Hair transplantation.
   - Lip augmentation.
   - Lip reduction.
   - Liposuction.
   - Mastopexy.
   - Pectoral implants for chest masculinization.
   - Rhinoplasty.
   - Skin resurfacing.
   - Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
   - Voice modification surgery.
   - Voice lessons and voice therapy.

These exclusions do not apply to any specific service or treatment listed as covered elsewhere in this document.

Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. Prescribed or non-prescribed medical and disposable supplies. Examples of supplies that are not covered include, but are not limited to:

   - Elastic stockings, ace bandages, diabetic strips, and syringes.
   - Urinary catheters.

   This exclusion does not apply to:

   - Ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 5, *Additional Coverage Details*.
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 5, *Additional Coverage Details*.

3. Tubings, nasal cannulas, connectors and masks that are not used in connection with DME.

4. Orthotic appliances that straighten or re-shape a body part (including some types of braces). Examples of excluded orthotic appliances and devices include, but are not limited to, foot orthotics or any orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

5. Cranial banding.

6. Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 5, *Additional Coverage Details*.

Mental Health, Neurobiological Disorders - Autism Spectrum Disorder Services and Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 6, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services in Section 5, Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, gambling disorder, and paraphilic disorder.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

5. 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*.

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

7. Transitional Living services, sober living and halfway house services.

8. Non-medical 24-hour withdrawal management.

9. High intensity residential care, including *American Society of Addiction Medicine (ASAM)* criteria, for Covered Persons with Substance-Related and Addictive Disorders who are unable to participate in their care due to significant cognitive impairment, is not covered under the Plan as a Mental Health benefit, as these services are primarily medical in nature.

10. Wilderness, adventure, outdoor therapies, as well as assisted therapy services which would include incorporating animals into the services (such as equine, dolphin or any other type of animal).

11. Services provided in unlicensed, and/or non-accredited program. Treatment or services that are non-professionally directed.

Nutrition and Health Education

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

2. Food of any kind. Foods that are not covered include:

   - Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, except as described under *Enteral Feedings, Nutritional Supplements, Vitamins and Electrolytes* in Section 5, *Additional Coverage Details*. Infant formula available over the counter is always excluded.
   - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
   - Oral vitamins and minerals.
   - Meals you can order from a menu, for an additional charge, during an Inpatient Stay.
   - Other dietary and electrolyte supplements.

3. Health club memberships and programs, and spa treatments.

4. Health education classes unless offered by UMR or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 10, *Glossary*. Examples include:

    - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
    - Pharmacological regimens, nutritional procedures or treatments.
    - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).

2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note**: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 5, *Additional Coverage Details*.

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.

4. Weight loss programs unless they are under medical supervision or for medical reasons even if for morbid obesity.

5. Treatments for hair loss.

6. A procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy unless Medically Necessary.

7. Varicose vein treatment of the lower extremities, when it is considered cosmetic.

8. Treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. Biofeedback.

2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea. CPAP or BiPAP for sleep apnea requires three month rental prior to purchase and must be Medically Necessary.

3. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.

4. Speech therapy to treat stuttering, stammering, or other articulation disorders with the exception of speech therapy for stuttering due to an illness or Injury.

5. Rehabilitation services for speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder as identified under *Rehabilitation*

Services - Outpatient Therapy and Manipulative Treatment in Section 5, *Additional Coverage Details*.

6. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.

7. Psychosurgery (lobotomy).

8. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

9. Chelation therapy, except to treat heavy metal poisoning.

10. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

11. The following treatments for obesity:

    - Non-surgical treatment of obesity, even if for morbid obesity.
    - Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 5, *Additional Coverage Details*.

12. Medical and surgical treatment of excessive sweating (hyperhidrosis) unless Medically Necessary.

13. The following services for the diagnosis and treatment of temporomandibular joint syndrome (TMJ): surface electromyography, Doppler analysis, vibration analysis, computerized mandibular scan or jaw tracking, craniosacral therapy, orthodontics, occlusal adjustment, and dental restorations.

14. Breast reduction surgery that is determined to be a Cosmetic Procedure.

    This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in Section 5, *Additional Coverage Details*.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child. This includes any service the providers may perform on themselves.

2. Services performed by a provider with your same legal residence.

3. Services ordered or delivered by a Christian Science practitioner.

4. Services performed by an unlicensed provider or a provider who is operating outside of the scope of their license.

Reproduction

1. The following infertility treatment-related services:

    - Storage (beyond an initial 12 months) of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue.
    - Donor services and Non-medical costs of oocyte or sperm donation (e.g., donor agency fees).
    - Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
    - Natural cycle insemination in the absence of sexual dysfunction or documented cervical trauma.
    - All costs associated with surrogate motherhood; non-medical costs associated with a gestational carrier.
    - Ovulation predictor kits.

2. Surrogate parenting, donor oocytes (eggs), donor sperm and host uterus unless Medically Necessary.

3. Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.

4. The reversal of voluntary sterilization.

Services Provided under Another Plan

Services for which coverage is available:

1. Under another Plan, except for Eligible Expenses payable as described in Section 8, *Coordination of Benefits (COB).*

2. Under workers' compensation, or similar legislation if you could elect it, or could have it elected for you.

3. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

4. While on active military duty.

5. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

Transplants

1. Health services for organ and tissue transplants,

    - except as identified under *Transplantation Services* in Section 5*, Additional Coverage Details*.

- determined by Accolade not to be proven procedures for the involved diagnoses.
- not consistent with the diagnosis of the condition.

2. Health services for transplants involving permanent mechanical or animal organs.

3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging Assistance Program* in Section 5, *Additional Coverage Details*. . Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 5, *Additional Coverage Details*.

Vision and Hearing

1. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants).

2. Purchase cost and associated fitting charges for eyeglasses or contact lenses except as described in *Eye Examination* in Section 5*, Additional Coverage Details*.

3. Bone anchored hearing aids except when either of the following applies:

   - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
   - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.

4. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.

2. Charges for:

- Missed appointments or late arrivals.
- Room or facility reservations.
- Completion of claim forms.
- Record processing.
- Services, supplies or equipment that are advertised by the Provider as free.

3. Charges by a Provider sanctioned under a federal program for reason of fraud, abuse or medical competency.

4. Charges prohibited by federal anti-kickback or self-referral statutes.

5. Chelation therapy, except to treat heavy metal poisoning.

6. Custodial Care as defined in Section 10, *Glossary*, or services provided by a personal care assistant.

7. Diagnostic tests that are:

   - Delivered in other than a Physician's office or health care facility.
   - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.

8. Domiciliary Care, as defined in Section 10, *Glossary*.

9. Growth hormone therapy.

10. Expenses for health services and supplies:

    - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
    - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
    - For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan.
    - That exceed Eligible Expenses or any specified limitation in this Benefits Summary.

11 In the event a Non-Network provider waives, does not pursue, or fails to collect the Coinsurance, any Deductible or other amount owed for a particular health service, no Benefits are provided for the health service for which the Coinsurance and/or Deductible are waived.

12. Foreign language and sign language services.

13. Long term (more than 30 days) storage of blood, umbilical cord or other material.

14. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 10, *Glossary*. Covered Health Services are those health

services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this Benefits Summary under Section 5, *Additional Coverage Details* and in Section 4, *Plan Highlights*.
- Not otherwise excluded in this Benefits Summary under this Section 6, *Exclusions and Limitations*.

This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.

15. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded.

    This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

16. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer). Appliances for snoring are always excluded.

17. Private Duty Nursing received on an inpatient basis.

18. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under *Hospice Care* in Section 5, *Additional Coverage Details*.

19. Rest cures.

20. Speech therapy to treat stuttering, stammering, or other articulation disorders.

21. Speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, Sickness, stroke, cancer, Autism Spectrum Disorder or a Congenital Anomaly, or is needed following the placement of a cochlear implant as identified under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* in Section 5, *Additional Coverage Details*.

22. Manipulative Treatment to treat a condition unrelated to alignment of the vertebral column, such as asthma or allergies.

23. Storage of blood, umbilical cord or other material for use in a Covered Health Service, except if needed for an imminent surgery.

24. The following treatments for obesity:

    - Non-surgical treatment, except for morbid obesity.
    - Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 5, *Additional Coverage Details*.

25. Treatment of hyperhidrosis (excessive sweating) unless Medically Necessary.

26. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

27. Wilderness, adventure, outdoor therapies, as well as assisted therapy services which would include incorporating animals into the services (such as equine, dolphin or any other type of animal).

SECTION 7 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work.
- What to do if your claim is denied, in whole or in part.

Claims Administrator Addresses for Filing Claims and Appeals for Benefits

FOR INITIAL CLAIMS	FOR APPEALS:
UMR	UMR
ME, NH & MA Claims Health Plans, Inc. PO Box 5199 Westborough, MA 01581	*Send Post-Service Claim Medical appeals to:* UMR CLAIMS APPEAL UNIT PO BOX 30546 SALT LAKE CITY UT 84130-0546
Outside ME, NH & MA Claims UMR PO Box 30541 Salt Lake City, UT 84130-0541	*Send Pre-Service Claim Medical appeals to:* UHC APPEALS - UMR PO BOX 400046 SAN ANTONIO TX 78229
For out-of-network UMR PO Box 8033 Wausau, WI 54402-8033	
Behavioral Health Benefit Claims: Optum Behavioral Health PO Box 30757 Salt Lake City, UT 84130-0757	**Behavioral Health Benefit Appeals:** Optum Appeals & Grievances PO Box 30512 Salt Lake City, UT 84130-0512

How to File an Initial Claim – Network Benefits

In general, if you receive Covered Health Services from a Network provider, UMR will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Coinsurance, please contact the provider or call Accolade at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

How to File an Initial Claim – Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UMR for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UMR at the address on the back of your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **member.accolade.com**, calling the toll-free number on your ID card or by contacting Accolade. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Employee.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician or provider.
- The date of service.
- An itemized bill from the provider that includes:
  - The *Current Procedural Terminology (CPT)* codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.
  - A statement indicating either that the patient is, or is not, enrolled for coverage under any other health insurance plan or program. If the patient is enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UMR at the address shown in the SPD and on your ID card.

After UMR has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Anti-Assignment and Payment of Benefits

An assignment of Benefits by a Covered Person to a provider is not permitted under the Plan. Any attempt to assign, transfer, anticipate, alienate, sell, pledge, encumber, charge, garnish, execute, or levy upon, or otherwise dispose of any rights, Benefits, or causes of action under the Plan shall be void and unenforceable. This prohibition applies to all rights and interests under the Plan, including rights to Benefits, claims for fiduciary breach, claims for statutory penalties, and any other rights that may be asserted by you under or related to the Plan.

The Claims Administrator, in its sole discretion, may pay Benefits directly to a provider that provides services to you, but will treat you, rather than the provider, as the beneficiary of your claim. You have no authority or right to obligate the Claims Administrator or the Company to make direct payment to a provider. Any attempt to obligate a Claims Administrator or the Company to make direct payment to a health care provider is void and

unenforceable. Further, the Plan does not create any right or legal relationship or third-party beneficiary status between the Company or the Claims Administrator and any provider.

Explanation of Benefits (EOB)

You may request that UMR send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **member.accolade.com**. See Section 10, *Glossary*, for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted within 18 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense. This 18-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Pre-Determination of Benefits

A Pre-Determination is a determination of Benefits by the Claims Administrator, on behalf of the Plan, prior to services being provided. Although Pre-Determinations are not required by the Plan, a Covered Person or provider may voluntarily request a Pre-Determination. A Pre-Determination informs individuals of whether, and under which circumstances, a procedure or service is generally a covered benefit under the Plan. A Covered Person or provider may wish to request a Pre-Determination before incurring medical expenses. A Pre-Determination is not a claim and therefore may not be appealed. A Pre-Determination that a procedure or service may be covered under the Plan does not guarantee the Plan will ultimately pay the claim. All Plan terms and conditions will still be applied when determining whether a claim is payable under the Plan.

Claim Denials and Appeals Procedures for Claims for Benefits

Types of claims
The timing of the claims appeal process is based on the type of claim involved. For claim and appeals procedures, it helps to understand whether the claim is an:

- Urgent care claim - A pre-service claim for Benefits where the otherwise applicable timeframes for obtaining approval either: (1) could seriously jeopardize the claimant's life or health or ability to regain maximum function, or (2) in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be managed adequately without the care or treatment.
- Pre-service claim - A claim for Benefits that, by its terms, conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

- Post-service claim - A claim for Benefits under a group health plan that is not a pre-service claim or an urgent care claim.
- Concurrent care claim – A concurrent care claim occurs where the Plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (1) where reconsideration of previously approved care results in a reduction or termination of the initially approved period of time or number of treatments; and (2) where an extension is requested beyond the initially approved period of time or number of treatments.

Throughout this section "claimant" refers to the individual with the claim for Benefits and includes any authorized representative. In many cases, a claimant's initial claim for Benefits is filed when they or their provider submits a request for Benefits to the Claims Administrator. In response to submission of this claim, the claimant receives an "Explanation of Benefits" from the Claims Administrator, which indicates if the claim for Benefits was approved or denied (either in full or in part).

Authorized Representative

A Covered Person is permitted to appoint an authorized representative to act on their behalf with respect to any claim or appeal of a denied claim under the Plan (whether a claim for Benefits or a claim for eligibility). To appoint such representative, the Covered Person should contact the Claims Administrator. Once an authorized representative is appointed, the Plan shall direct all information regarding the claim to the authorized representative.

However, for an urgent care claim, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without further verification or documentation, unless the Covered Person provides specific written direction otherwise.

Any designation or authorization for purposes of payment (e.g., to a health care professional) does not constitute appointment of an authorized representative under these claims procedures.

Initial Claim Decision

The Claims Administrator must notify the claimant of its benefit determination within the time frames below, provided the claim is not missing any information, based on the type of claim filed:

- Initial urgent care claim – within 72 hours of receipt of the claim
- Initial pre-service claim – no later than 15 days after receipt of the claim
- Initial post-service claim – no later than 30 days after receipt of the claim

Missing Information

If a claimant files an urgent care claim and it is missing information, the Claims Administrator must notify the claimant no later than 24 hours after it receives an urgent care

claim. In this case, the Claims Administrator must give the claimant 48 hours to provide the missing information. The Claims Administrator shall decide the claim as soon as possible but not later than 48 hours after the earlier of: (a) receipt of the specified information; or (b) the end of the period of time provided to the claimant to submit the information.

If a claimant files a pre-service or a post-service claim and it is missing information, the Claims Administrator may, but is not required to, notify the claimant that information is missing. However, if the claimant is notified that information is missing, the Claims Administrator must give the claimant 45 days to provide the missing information. The timeframe for deciding the claim shall be suspended until the date the missing information is provided to the applicable Claims Administrator. If the requested information is not provided within the timeframe specified, the claim may be decided without that information.

Incorrectly Filed Claims

Incorrectly filed claims refer to claims that are not considered a "claim" because the claim is not made in accordance with these claims procedures. If the claimant files an urgent care claim incorrectly, he/she will be notified as soon as possible but no later than 24 hours following the Claims Administrator's receipt of the incorrectly filed claim. If the claimant files a pre-service claim incorrectly, he/she will be notified as soon as possible but no later than 5 days following the Claims Administrator's receipt of the incorrectly filed claim.

Extension of Time to Make Initial Claim Determination

If the Claims Administrator is unable to make a benefit determination within the timeframes set forth above due to reasons beyond its control, the Claims Administrator may extend the timeframes for pre-service and post-service claims as follows:

- Initial pre-service claim – up to an additional 15 days
- Initial post-service claim – up to an additional 15 days

In the case of an extension, the Claims Administrator must notify the claimant in writing prior to the expiration of the initial review period. In addition, the extension notice must explain why the extension is necessary, the date by which the Claims Administrator expects to make a determination, and, if applicable, the additional information that is needed to make the determination. Please note, no extension is available for urgent care claims.

Notification of Initial Claim Decision

Written notification of the applicable Claims Administrator's decision for urgent and pre-service claims shall be provided to the claimant regardless of whether the claim is denied.

If a claim for Benefits under a group health plan is denied, in whole or in part, the Claims Administrator will notify the claimant of the denial in writing, and if necessary, in a culturally and linguistically appropriate manner according to applicable requirements. The denial notice will, in a manner calculated to be understood by the claimant:

- Provide information sufficient to identify the claim and statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning.

- Explain the specific reason(s) why the claim was denied.
- Reference the applicable group health plan's provision(s) on which the denial is based.
- Describe any additional material or information that would be required to reconsider your claim and why that material or information is necessary.
- Explain the applicable group health plan's appeal procedures and external review rights.
- Provide either a copy of any internal rule, guideline, or protocol relied upon in making the determination or a statement that such rule, guideline, or protocol was relied upon in making the determination and that it will be provided, upon request, free of charge.
- Explain any scientific or clinical judgment involved in the determination, or state that such an explanation will be provided, upon request, free of charge.
- In the case of an urgent care claim, provide an explanation of the expedited review methods available for such claims.
- Provide contact information for the U.S. Department of Labor's Employee Benefits Security Administration and any applicable state consumer assistance program.

The claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for Benefits.

If a claim for Benefits is denied in part or in whole, the claimant may call Accolade at the number on their ID card before requesting a formal appeal. If Accolade cannot resolve the issue, the claimant has the right to file a formal appeal as described below.

How to Appeal a Denied Claim for Benefits

If the claimant wishes to appeal the denial of their claim for Benefits, the claimant must file a complete written appeal no later than 180 days after receipt of the initial claim denial notice. However, for denied urgent care claims only, the claimant may submit the appeal orally or in writing. Appeals should be submitted to the Claims Administrator at the address set forth below. The appeal should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of medical service.
- The reason the claimant disagrees with the denial.
- Any documentation or other written information to support your request.

The claimant or their authorized representative may send a written request for an appeal to the Claims Administrator at the address provided at the beginning of this Section 7.

For Urgent Care requests for Benefits that have been denied, you or your provider can call Accolade at the toll-free number on your ID card to request an appeal.

Review of an Appeal

Any filed appeal(s) will not be reviewed by the same person, or a subordinate of the person, who made the initial denial and deference will not be given to the initial review(s). In addition, if the appeal involves medical judgment, the Claims Administrator will consult with an appropriately trained medical professional (e.g., a Physician or other professional licensed, accredited, or certified under state law to perform specified medical functions) who has experience in the field of medicine involved in the medical judgment. The appropriately trained medical professional consulted for the appeal will not be the same professional, or a subordinate of the person, consulted in the initial denial of Benefits.

The claimant will have the opportunity to submit written comments, documents, records, and other information related to their appeal for Benefits. The claimant also has the right to review the claim file, upon request and free of charge. The claimant can present evidence and testimony as part of the appeals process. If the Claims Administrator on appeal has considered, relied upon, or generated any new or additional evidence in deciding the claim, the claimant will be provided with such evidence sufficiently in advance of the due date for filing the appeal so you have the opportunity to respond to such additional evidence. Also, if a new or additional rationale is the basis for the decision, the claimant will be provided with the rationale, free of charge, as soon as possible and in advance of the date of the decision, so he/she has the opportunity to respond. The review shall take into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim decision.

The Claims Administrator must notify the claimant of its decision on appeal within the timeframes below, based on the type of claim he/she is appealing:

- Appeal of Urgent Care Claim – within 72 hours of receipt of appeal
- Appeal of Pre-Service Claim – no later than 15 days after receipt of appeal
- Appeal of Post-Service Claim – no later than 30 days after receipt of appeal

Notification of Appeal Decision

If an appeal is denied, in whole or in part, the notification of appeal decision will include, in a manner calculated to be understood by the claimant:

- information sufficient to identify the claim and statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning.
- the specific reason(s) why the claim was denied.
- the applicable group health plan's provision(s) on which the denial is based.
- a copy of any internal rule, guideline, or protocol relied upon, or a statement that such rule, guideline, or protocol will be provided to the claimant, upon request, free of charge.

- to the extent that any scientific or clinical judgment was used in making the determination, an explanation of such or a statement that such explanation will be provided, upon request, free of charge.
- a statement regarding the claimant's right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the appeal.
- information describing the applicable group health plan's external review rights and the claimant's right to bring suit under ERISA §502(a).
- contact information for the U.S. Department of Labor's Employee Benefits Security Administration and any applicable state consumer assistance program.

The notice may be provided in a culturally and linguistically appropriate manner according to applicable requirements.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a voluntary second level appeal from the Claims Administrator within 60 days from receipt of the first level appeal determination. To file a second appeal, follow the same instructions for information to include and where to send the appeal as set forth in the section above on How to Appeal a Denied Claim for Benefits. Note that the same procedures apply to the second appeal as to the first appeal as set forth above in the sections on Review of an Appeal and Notification of Appeal Decision, including without limitation the timing of when the Claims Administrator must provide a decision on appeal.

Federal External Review Program

The claimant can request external review of a final appeal determination by filing a request for external review within 4 months after the date of receipt of the notice of final appeal determination. The process is available at no charge to the claimant. To request standard external review, send a written request to the address set forth in the notice of final appeal determination.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

Eligibility for External Review

Within 5 business days following the date of receipt of an external review request, a preliminary review of the request will be performed to determine whether the claim is

eligible for external review. Claims eligible for external review are only those that involve an adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.
- The claimant may request a standard external review by sending a written request to the address set out in the determination letter. The claimant may request an expedited external review, in urgent situations as detailed below, by calling the number on their ID card or by sending a written request to the address set out in the notice of final appeal determination.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UMR of the request.
- A referral of the request by UMR to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UMR will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UMR may process the request.

After UMR completes the preliminary review, UMR will issue a notification in writing to the claimant. If the request is eligible for external review, UMR will assign an IRO to conduct such review. UMR will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify the claimant in writing of the request's eligibility and acceptance for external review. The claimant may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UMR will provide to the assigned IRO the documents and information considered in making UMR's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by UMR.
- All other information or evidence that the claimant or their Physician submitted. If there is any information or evidence the claimant or their Physician wish to submit that was not previously provided, the claimant may include this information with your external review request and UMR will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UMR. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to the claimant and UMR, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UMR's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding Plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances the claimant may file an expedited external review before completing the internal appeals process.

The claimant may make a written or verbal request for an expedited external review if the claimant receives either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain

maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received Emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UMR will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UMR may process the request.

After UMR completes the review, UMR will immediately send a notice in writing to the claimant. Upon a determination that a request is eligible for expedited external review, UMR will assign an IRO in the same manner UMR utilizes to assign standard external reviews to IROs. UMR will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UMR. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UMR.

You may contact UMR at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Notification of the IRO's decision

The IRO will provide written notice of the final external review decision to the claimant, and the notice will contain:

- a general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial;
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in making its decision;

- a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to the plan or claimant;
- a statement that judicial review may be available to the claimant; and
- current contact information for any applicable office of health insurance consumer assistance or ombudsman.

To the extent the final external review decision reverses the Claims Administrator's decision, the Plan shall follow the final external review decision of the IRO.

Timing of Claims and Appeals Procedures for Benefit Claims

Below is a summary of the timing outlined in the above provisions that applies to the claims and appeals procedures for claims for Benefits.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UMR must notify you within:	**24 hours**
You must then provide completed request for Benefits to UMR within:	**48 hours** after receiving notice of additional information required
UMR must notify you of the benefit determination within:	**72 hours**
If UMR denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UMR must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call Accolade as soon as possible to appeal an Urgent Care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UMR must notify you within:	**5 days**
If your request for Benefits is incomplete, UMR must notify you within:	**15 days**

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
You must then provide completed request for Benefits information to UMR within:	**45 days**
UMR must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UMR must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You may appeal the first level appeal (file a voluntary second level appeal) within:	**60 days** after receiving the first level appeal decision
UMR must notify you of the voluntary second level appeal decision within:	**15 days** after receiving the voluntary second level appeal

*UMR may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UMR must notify you within:	**30 days**
You must then provide completed claim information to UMR within:	**45 days**
UMR must notify you of the benefit determination:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination

Post-Service Claims	
Type of Claim or Appeal	**Timing**
UMR must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You may appeal the first level appeal (file a voluntary second level appeal) within:	**60 days** after receiving the first level appeal decision
UMR must notify you of the voluntary second level appeal decision within:	**30 days** after receiving the voluntary second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UMR will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against Fidelity or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Fidelity or the Claims Administrator, you must do so within one year from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Fidelity or the Claims Administrator.

You cannot bring any legal action against Fidelity or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Fidelity or the Claims Administrator you must do so within one year of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against Fidelity or the Claims Administrator.

Deemed Exhaustion of Internal Claims and Appeals Processes

In any case that the Plan does not adhere to all the requirements of this section with respect to a claim for Benefits, the claimant shall be deemed to have exhausted the internal review claims and appeal process of this section, except as otherwise provided in the next paragraph. Accordingly, the claimant may initiate an external review under the provisions of this section, as set forth above, as applicable. The claimant shall also be entitled to pursue any available remedies under Section 502(a) of ERISA. If a claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review.

Notwithstanding the foregoing, the internal review claims appeals process of this section will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the claimant. The claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within ten (10) days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal review claims appeals process of this paragraph to be deemed exhausted. If an external reviewer or a court rejects the claimant's request for immediate review under this section on the basis that the Plan met the standards for the exception under this paragraph, the claimant has the right to resubmit and pursue the internal review appeal of the claim for Benefits. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed ten (10) days), the Plan shall provide the claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon claimant's receipt of such notice.

SECTION 8 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans.
- How coverage is affected if you become eligible for Medicare.
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health Benefits Plan, including any one of the following:

- Another employer sponsored health Benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment Benefits or personal Injury protection Benefits under an auto insurance policy.
- Medical payment Benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its Benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its Benefits based on the Benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

Don't forget to update Medical Coverage Information for your Dependents.
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **member.accolade.com** or call the toll-free number on your ID card to update your COB information. You will need the name of the other medical coverage, along with the policy number, for each Dependent.

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal Injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay Benefits first.
- A plan that covers a person as an employee pays Benefits before a plan that covers the person as a Dependent.

- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- Your Dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays Benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - The parents are married or living together whether or not they have ever been married and not legally separated.
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If two or more plans cover a Dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - The parent with custody of the child; then
  - The Spouse of the parent with custody of the child; then
  - The parent not having custody of the child; then
  - The Spouse of the parent not having custody of the child.
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan - Examples
1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on the allowable expense.
- If this Plan would have paid the same amount or less than the primary plan paid, this Plan pays no Benefits.
- If this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

You will be responsible for any Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the allowable expense.

Determining the Allowable Expense If This Plan is Secondary

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's Network rate. When the provider is a Network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's Network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this Plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When This Plan is Secondary to Medicare".

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays Benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, domestic partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

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 reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an

"explanation of Medicare Benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare Benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare Benefits), Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience UMR will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

If This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on the primary plan's allowable expense.
- If this Plan would have paid less than the primary plan paid, the Plan pays no Benefits.
- If this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

The maximum combined payment you can receive from all plans may be less than 100% of the allowable expense.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary Benefits for these expenses. Your Dependent will also have this automated Crossover, as long as the individual is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare Benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses under Part A of Medicare (Hospital expenses) and to expenses under Part B (Physician office visits) and DME Medicare expenses or expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

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 plans. UMR may get the facts needed 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 plans covering the person claiming Benefits.

UMR does not need to tell, or get the consent of, any person to do this. Each person claiming Benefits under this Plan must give UMR any facts needed to apply those rules and determine Benefits payable. If you do not provide UMR the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Right to Request Overpayment

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person's coverage should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

SECTION 9 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be

entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation - Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement - Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

- Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
- Providing any relevant information requested by the Plan.
- Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident or injuries.
- Making court appearances.
- Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.

- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other

person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your Dependents or the Employee, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.

- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 10 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this Benefits Summary.

Many of the terms used throughout this Benefits Summary may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this Benefits Summary, but it does not describe the Benefits provided by the Plan.

Accolade Health Assistant – Accolade Health Assistants and nurses provide intensive management and support for individuals, and their families, with multiple chronic diseases, critical or traumatic events, and highly complex and high-acuity diagnoses.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the Amendment is specifically changing.

Annual Deductible (or Deductible) - the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 4, *Plan Highlights*.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Bariatric Resource Services (BRS) - a program administered by UMR or its affiliates made available to you by Fidelity. The BRS program provides:

- Specialized clinical consulting services to Employees and enrolled Dependents to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

BMI - see Body Mass Index (BMI).

Body Mass Index (BMI) - a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

Cancer Resource Services (CRS) - a program administered by UMR or its affiliates made available to you by Fidelity. The CRS program provides:

- Specialized consulting services, on a limited basis, to Employees and enrolled Dependents with cancer.
- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UMR and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in Section 2, *How the Plan Works*.

Company – FMR LLC ("Fidelity").

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health insurance coverage to certain Employees and their Dependents whose group health insurance has been terminated.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Cost Reduction Savings Program - a program in which UMR may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan Coinsurance and Deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UMR. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UMR. If this happens you should call the number on your ID Card. Cost Reduction Savings Program providers are not Network providers and are not credentialed by UMR.

Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Medically Necessary.
- Described as a Covered Health Service in this Benefits Summary under Section 4, *Plan Highlights* and 5, *Additional Coverage Details*.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described in the SPD.
- Not otherwise excluded in this Benefits Summary under Section 6, *Exclusions and Limitations*.

Covered Person - either the Employee or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this Benefits Summary are references to a Covered Person.

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described in the SPD. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at **member.accolade.com** or the telephone number on your ID card.

DME - see Durable Medical Equipment (DME).

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses - for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UMR as stated below and as detailed in Section 2, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with UMR's reimbursement policy guidelines. UMR develops the reimbursement policy guidelines, in UMR's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UMR accepts.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so 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 any of the following:

- Placing the health of the Covered 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.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services - with respect to an Emergency, both of the following:

- A medical screening examination (as required under section *1867 of the Social Security* Act, *42 U.S.C. 1395dd*) that is within the capability of the Emergency department of a Hospital, including ancillary services routinely available to the Emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*

Employee - an employee of Fidelity who meets the eligibility requirements specified in the Plan, as described in the SPD.

EOB - see Explanation of Benefits (EOB).

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, Substance-Related and Addictive Disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)

- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under Clinical Trials in Section 5, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 5, *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UMR to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.
- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

Fertility Solutions (FS) - a program administered by UMR or its affiliates made available to you by Fidelity. The FS program provides:

- Specialized clinical consulting services to Employees and enrolled Dependents to educate on infertility treatment options.
- Access to specialized Network facilities and Physicians for infertility services.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

FS - see Fertility Solutions (FS).

Gender Dysphoria - A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association:*

- Diagnostic criteria for adults and adolescents:

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
- A strong desire for the primary and/or secondary sex characteristics of the other gender.
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

■ The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

■ Diagnostic criteria for children:

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
- A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
- In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
- A strong preference for cross-gender roles in make-believe play or fantasy play.
- A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
- A strong preference for playmates of the other gender.
- In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
- A strong dislike of ones' sexual anatomy.
- A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

■ The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, Substance-Related and Addictive Disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

Intensive Outpatient Treatment - a structured outpatient mental health or Substance-Related and Addictive Disorders treatment program that may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) - a program administered by UMR or its affiliates made available to you by Fidelity. The KRS program provides:

- Specialized consulting services to Employees and enrolled Dependents with ESRD or chronic kidney disease.
- Access to dialysis centers with expertise in treating kidney disease.
- Guidance for the patient on the prescribed plan of care.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic Manipulative Treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical Benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, Substance-Related and Addictive Disorders, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, Substance-Related and Addictive Disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Is the most appropriate care, supply, or drug that can be safely provided to the member and is at least as likely as an alternative service or sequence of services to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled Clinical Trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty

society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on **member.accolade.com** or by calling the number on your ID card, and to Physicians and other health care professionals on **www.umr.com**.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Mental Health/Substance-Related and Addictive Disorders Administrator - the organization or individual designated by Fidelity who provides or arranges Mental Health Services and Substance-Related and Addictive Disorder Services under the Plan.

Mental Illness - mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Cost Reduction Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit Plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 4, *Plan Highlights* to determine whether or not your Benefit Plan offers Network Benefits and Section 2, *How the Plan Works*, for details about how Network Benefits apply.

Non-Network Benefits - for Benefit Plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 4, *Plan Highlights* to determine whether or not your

Benefit Plan offers Non-Network Benefits and Section 2, *How the Plan Works*, for details about how Non-Network Benefits apply.

Out-of-Pocket Maximum - for Benefit Plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every calendar year. Refer to Section 4, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 2, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a freestanding or Hospital-based program and that provides services for at least 20 hours per week.

Pharmaceutical Product means any order authorized by a medical professional for a prescription or non-prescription drug that could be a medication or supply for the person for whom it is prescribed. The prescription must be compliant with all applicable laws and regulations and identify the name of the medical professional and the name of the person for whom it is prescribed. It must also identify the name, strength, quantity, and directions for use of the medication or supply prescribed.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of their license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - Fidelity Health Plan, which is a medical Plan option offered under all of the following wrap plans sponsored by FMR, LLC; Fidelity Group Employees Medical, Dental and Cafeteria Plan; Fidelity 2017 Voluntary Buyout Opportunity Plan; Fidelity 2021 Voluntary Buyout Opportunity Plan.

Plan Administrator – FMR, LLC.

Plan Sponsor – FMR, LLC.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Prescription Drug Program – The Prescription Drug Program, which is administered by CVS Caremark, is a component of the Plan and is described in the Prescription Drug Benefit Booklet which is available on FMRbenefit.com or by calling the Fidelity Benefits Center. For information about pharmacy claims and the Prescription Drug Program contact CVS

Caremark Customer Care toll free at 1-800-446-3709, visit caremark.com or contact Accolade.

Primary Physician - a Physician who has a majority of their practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a home setting when any of the following are true:

- The care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or their family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment - treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Services Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private

Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Benefits Summary includes Mental Illness or Substance-Related and Addictive Disorders, regardless of the cause or origin of the Mental Illness or Substance-Related and Addictive Disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Spouse - an individual to whom you are legally married.

SPD – refers to the Summary Plan Description for the Plan prepared by Fidelity and available on FMRbenefits.com or by calling the Fidelity Benefits Center at 800-835-5099.

Substance-Related and Additive Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and Substance-Related and Addictive Disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Transitional Living - Mental Health Services and Substance-Related and Addictive Disorder Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the

opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Urgent Care - care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent Care is usually delivered in a walk-in setting and without an appointment. Urgent Care facilities are a location, distinct from an Emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

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