Welcome to Accolade and Meritain Health

PayPal is partnering with Accolade and Meritain Health to provide comprehensive medical benefits and services for PayPal effective 1/1/23. If you have care that is in progress and/or upcoming care, we can help.

Should you be in the middle of care and / or have care that has recently been pre-authorized with United Health Care (UHC), please review the following information and know that Accolade – who provides customer and advocacy service to PayPal employees and their families - will be available to assist.

Transitional care

Your new medical plan includes a Transition of Care provision which is applicable to members who:

- Are currently undergoing a course of treatment from a physician that is in the United Health Care (UHC) network, but may not be in the Aetna network.
- May have care that has been recently prior-authorized with UHC. All previously approved pre-certifications are honored when you transition to Accolade's care support effective 1/1/23. UHC will be providing Accolade with a listing of services that have already been prior-authorized. However, you can also provide a copy of your pre-approval letter to your Accolade Health Assistant. If you don't have this, you can request it from your doctor.

Transition of care allows you to continue to receive medical services paid at the in-network level for a period of time, even if your current physician is considered out-of-network with the new Aetna Choice POS II administered by Meritain. You will be covered through the transitional care service provision.

Note that routine procedures, treatment for stable chronic conditions, minor illnesses and elective surgical procedures will not be covered by transitional level benefits. Those that are eligible must complete and return the Transition of Care Form. Examples of what types of services would be considered for Transition of Care are listed below along with how to contact Accolade should you have questions.

Who should I call with questions?

You or your dependent should call an Accolade Health Assistant at **1.866.406.1338** at any time to determine eligibility for the Transition of Care benefit, but within four weeks of your effective date of coverage at the latest. We are here to help.

Accolade PERSONALIZED HEALTHCARE

MERITAIN℠ HEALTH An Aetna Company

What types of services are subject to Transition of Care?

Following are examples of medical procedures and services that typically qualify for Transition of Care benefits.

Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

- Cancer if under active treatment with chemotherapy and/or radiation therapy.
- Organ transplant patients if under active treatment (seeing a doctor on a regular basis, on a transplant waiting list, ready at any time for transplant).
- If the covered person is inpatient in a hospital on the effective date.
- Post acute injury or surgery within the past three months.
- Pregnancy in the second or third trimester and up to six weeks postpartum.
- Behavioral health—any previous treatment.

What services typically require pre-certification?

Many medical procedures are subject to pre-certification – examples are listed below. If you have a pre-certification for any of these services, please feel free to share it with Accolade.

All Inpatient Admissions	
• Acute • Long-Term Acute Care • Hospice Care • Rehabilitation • Mental Health/ Substance Use Disorder • Transplant	• Skilled Nursing Facility • Residential Treatment Facility • Obstetric – Pre-notification only (precertification only required if days exceed Federal mandate)

Outpatient and Physician - Diagnostic Services	
• MRI (Magnetic Resonance Imaging) • MRA (Magnetic Resonance Angiography) • PET (Positron Emission Tomography)	• Capsule endoscopy • Genetic Testing (including BRCA) • Sleep Study (facility based)

Outpatient and Physician - Continuing Care Services	
• Chemotherapy (including oral) • Radiation Therapy • Oncology care including oncology and transplant related injections, infusions and treatments (e.g. CART, endocrine and immunotherapy excluding supportive drugs (e.g. antiemetic and antihistamine)	• Home Health Care related to occupational therapy, physical therapy, speech therapy and skilled nursing care done in the home • Durable Medical Equipment, limited to electric /motorized scooters or wheelchairs and pneumatic compression devices • Hyperbaric Oxygen • Durable Medical Equipment >$1K (excludes disposable supplies)

Outpatient and Physician - Surgery

- Thyroidectomy, Partial or Complete
- Prostate or Ovary Removal – include Open Prostatectomy / Oopherectomy
- Back Surgeries and hardware related to surgery
- Osteochondral Allograft, knee
- Hysterectomy (including prophylactic)
- Autologous chondrocyte implantation
- Potentially Cosmetic Procedures, including but not limited to:
  - Abdominoplasty
  - Blepharoplasty
  - Cervicoplasty (neck lift)
  - Facial skin lesions (Photo therapy, laser therapy - excluding MOHS)
  - Hernia repair, abdominal and incisional (only when associated with a cosmetic procedure)
  - IDET (thermal intradiscal procedures)
  - Liposuction/lipectomy
  - Mammoplasty, augmentation and reduction (including removal of implant)
- Transplant (excluding cornea)
- Balloon sinuplasty
- Sleep apnea related surgeries, limited to:
- Radiofrequency ablation (Coblation,
- Somnoplasty)
- Uvulopalatopharyngoplasty (UPPP) (including laser-assisted procedures)
- Mastectomy (including gynecomastia and prophylactic)
- Morbid obesity procedures
- Orthognathic procedures (e.g.Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
- Otoplasty
- Panniculectomy
- Rhinoplasty
- Rhytidectomy
- Scar revisions
- Septoplasty
- Varicose vein surgery/sclerotherapy

Medical Evacuation

- Air Ambulance for non-emergent transportations

Note: Precertification is also recommended if a procedure could be considered Experimental and/or Investigational.

CALL 911 IF YOU ARE HAVING A MEDICAL EMERGENCY. Accolade and its affiliates ("Accolade") are not an emergency medical service. Accolade provides a personalized healthcare information service to support you to better understand and utilize your benefits, receive information from expert medical resources, and facilitate your access to medical care from various healthcare professionals, including virtual medical care services. Virtual medical care services offered by Accolade are provided through independent professional medical practices, including under the PlushCare brand, to which Accolade provides various platform and related services

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WELCOME TO ACCOLADE AND MERITAIN HEALTH

Medical Form
Healthcare Transition of Care Request Form

Complete and send to:
Meritain Health
P.O. Box 853921
Richardson, TX 75085-3921
Customer service: 1.800.925.2272
Fax: 1.763.852.5078
Email: mnscan@meritain.com

This form represents a formal request to your health plan to cover continuing care from an out-of-network treating provider for a specified period of time. You will receive a coverage determination by mail. If this coverage request is not approved, care by the out-of-network provider after the Plan's effective date, or after the end of the provider's contract with the primary preferred network, will be processed at the out-of-network benefit level (based on your specific plan).

Please note this form is to be completed only if:

- You or a covered family member are using a doctor who does not participate in your primary preferred network of doctors or hospitals (the Aetna Choice POS II network, administered by Meritain Health) and you are currently undergoing a course of active treatment.
- You or a covered family member have an upcoming scheduled surgery or planned hospital admission at a facility not in your primary preferred network.

A list of medical conditions allowable for consideration for transitional care are outlined in your Summary Plan Description (SPD). Please review the SPD for Transition of Care coverage details and deadlines for when this form must be received to have your request reviewed.

This Transition of Care Request form is not to be interpreted as a guarantee of benefits. Benefits are subject to the plan provisions outlined in the SPD and are applicable to deductibles, coinsurance, plan maximums, etc. If approved, the letter of transition approval will be based on the assumption that the claimant will receive these services while covered under the plan, follow all other plan provisions, as applicable, and that the treatment plan will not change. Final benefit determination will be made upon receipt of the claim.

EMPLOYEE INSTRUCTIONS

1. Please complete sections 1, 2 and 3.
2. Read the authorization, and sign and date this part of the form. If the patient is age 17 or older, he or she must also sign and date this form.
3. Give the form to the patient's out-of-network treating doctor or healthcare provider, who will complete section 4 and fax, mail or email the completed form to Meritain Health.

1. Employer Information	Employer's name (please print) **PayPal, Inc.**	Plan effective date (required) **1/1/2023**
2. Employee/Patient Information	Employee's name (please print)	Identification number (or Social Security number)
	Employee's address (please print)	Date of birth (mm/dd/yyyy)
	Patient name (please print)	Telephone number
3. Authorization	I am requesting coverage for continuing care by the provider named below for a condition for which for which I am currently receiving care that was started before my plan effective date or before the end of the provider's contract with the primary preferred network. If approved, I understand the continuing care specified below will be covered for a limited period. I further understand that coverage will be subject to the benefits, exclusions, limits and maximums of my plan as of the date services are rendered. I authorize the physician named below to provide medical information or records to the plan as required, to make a coverage determination.	
	Patient's signature (required if patient is 17 or older)	Date (mm/dd/yyyy)
	Parent's signature (required if patient is 16 or younger)	Date (mm/dd/yyyy)

4. Provider Information

Although you are not or soon will not be a participating provider in the Plan network, the patient has requested that we cover care provided by you for a specified period of time because of a condition requiring an active course of treatment (for example a pregnancy). So we can evaluate your patient's request, please complete the information requested below. Please include a brief statement of the member's current condition and treatment plan. **For pregnancies, please enter the patient's Estimated Date of Confinement (EDC).**

Name of treating doctor or healthcare provider (please print)	Telephone number
Name of out-of-network physician's group practice (please print)	Provider tax ID
Address of treating doctor or healthcare provider (please print)	
Hospital where treating doctor or healthcare provider practices	Hospital telephone number
Patient's diagnosis	**Expected length of treatment**

Patient's current condition

1. Is the patient pregnant? ☐ Yes ☐ No
   If yes, when is the expected delivery date? (mm/dd/yyyy) _____
2. Is the patient currently receiving treatment for an acute condition or trauma? ☐ Yes ☐ No
3. Is the patient scheduled for surgery or hospitalization? ☐ Yes ☐ No
   Expected date of surgery/admission: _____
4. Is the patient involved in a course of chemotherapy, radiation therapy, cancer therapy, terminal care or a candidate for organ transplant? Specify ☐ Yes ☐ No
5. If treatment requested is related to an organ transplant, was the patient actively on the waiting list? If yes, please provide the date he or she was added to the waiting list. ☐ Yes ☐ No ☐ N/A Date:___/____/____
6. Is the patient receiving treatment as a result of a recent major surgery? ☐ Yes ☐ No
7. Is the patient receiving mental health/substance use treatment? ☐ Yes ☐ No
8. If you did not answer yes to any of the above questions, please describe the condition for which the patient requests transition of care:

Describe treatment plan and treatment dates
**If patient is receiving cancer treatment, please include treatment medications, dosages, frequency, etc.*

In the event this request is approved, you agree to provide the member's treatment and follow-up; to not seek payment from the member for any amount that the member would not be responsible for if you were a participating provider; to share information regarding the treatment plan with us; and, to use the plan's primary preferred network of provider for any necessary referrals, lab work or hospitalizations. Since you no longer are a participating provider, your claim will be processed at the usual and customary rate applicable to the services rendered.

Signature of treating doctor or healthcare provider	**Date (mm/dd/yyyy)**